Aetna Better Health

2019 Compliance Audit

Review Period: April 01, 2018 – March 31, 2019

Final Report Issued December 2019

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

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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Introduction and Audit Overview

Introduction

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

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct annual compliance audits every three years. The 2019 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019.

This report presents IPRO's findings of the 2019 annual compliance audit for Aetna Better Health (Aetna).

Audit Overview

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

The audit included a comprehensive evaluation of Aetna's policies, procedures, files, and other materials corresponding to the following nine contractual domains:

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

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

Specifically, file review consisted of the following six areas:

1. Member Grievances
2. Appeals
3. Informal Reconsiderations
4. Case Management (behavioral and physical health)
5. Credential/Recredentialing
6. Utilization Management

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Member Grievances	15
Appeals	10
Informal Reconsiderations	5
Case Management (physical health)	10
Case Management(behavioral health)	10
Credential/Recredentialing	10
Utilization Management	10

The period of review was April 1, 2018 through March 31, 2019. All documents and case files reviewed were active during this time period.

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

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not Applicable	The requirement was not applicable to the MCO.

The 2019 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit, and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared nine review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in April 2019. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the MCO in April 2019 in advance of the onsite audit.

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

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also

provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

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

After the MCO submitted the required documentation, a team of three experienced IPRO auditors was convened to review the MCO's policies, procedures, and materials, and to assess the MCO's concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the onsite review discussion.

Onsite Visit

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

The IPRO audit team visited Aetna on July 17 and 18, 2019, to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and to allow the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy in accordance to state standards. MCO staff was given two days from the close of the onsite review to provide any further documentation.

Post-onsite Report Preparation

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

Each draft report underwent a second level of review by IPRO staff members who were not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval, the draft reports were sent to the MCO with a request to provide responses for all elements that were determined to be less than fully compliant. The MCO was given one week to respond to the issues noted on the draft reports.

After receiving the MCO's response, IPRO re-reviewed each element for which the MCO provided a response. As necessary, review scores were updated based on the response of the MCO.

MCO Summary of Findings

Summary of Findings

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

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Core Benefits and Services	115	115	0	0	0	0	100%
Provider Network Requirements	184	156	23	5	0	0	85%
Utilization Management	87	86	1	0	0	0	99%
Eligibility, Enrollment, and Disenrollment	13	6	5	1	1	0	46%
Marketing and Member Education	83	63	10	9	1	0	76%
Member Grievance and Appeals	65	62	2	0	1	0	95%
Quality Management	114	107	5	0	0	2	96%
Fraud, Abuse, and Waste Prevention	118	118	0	0	0	0	100%
Reporting	1	1	0	0	0	0	100%
TOTAL	**780**	**714**	**46**	**15**	**3**	**2**	**92%**

[1] N/As are not included in the calculation.

As presented in **Table 3**, 780 elements were reviewed for compliance. Of the 780, 714 were determined to fully meet the regulations, while 46 substantially met the regulations, 15 minimally met the regulations and 3 were determined to be non-compliant. Two elements were "not applicable." The overall compliance score for Aetna was 92% elements in full compliance.

IPRO extracted from each of the nine detailed reports those elements for which the MCO was found to be less than fully compliant. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, the MCO's initial response, and, when possible, suggestions to achieve full compliance.

It is the expectation of both IPRO and the LDH that Aetna submit a corrective action plan for each of the 64 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that Aetna may have implemented corrective actions for some areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response since they were made after the period of review. The majority of the elements determined to be less than fully complaint related to providers and members, specifically provider network adequacy (a common problem in the Louisiana Medicaid Managed Care program) and member education and enrollment. Aetna should direct improvement efforts in both of these areas, especially to ensure that its member policies and procedures are up to date and reflect the state's regulations and to continue outreaching to recruit providers, especially in key areas such as specialists and sub-specialists.

Each of the nine review tools and review determinations for each of the 780 elements follow **Table 4**. Note that the yellow highlighting in the element descriptions reflects new language in the state regulations that was added since the 2016 compliance review period.

Table 4: Deficient 2019 Audit Elements

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Provider Network Requirements					
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the NPDMP on page 12. Per Geo Access reports the member ratios meet the standard met in the Provider Network Companion Guide. Not all adult members in urban parishes had access to PCPs within 10 miles. All adult members in rural parishes had access to PCPs within 30 miles. Only 75% pediatric members in urban and 98% of rural parishes had access to PCPs within 10 and 30 miles, respectively. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
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.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the NPDMP on page 12. Not all members living in urban or rural parishes had access to acute inpatient hospitals within 10 and 30 miles, respectively. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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 the Provider Network Companion Guide.. LDH 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 LDH for this purpose.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the NPDMP on pages 16 and 17. Access criteria for ob/gyns in urban parishes are 15 miles/30 minutes and in rural parishes are 30 miles/60 minutes, as indicated in the Provider Network Companion Guide. Not all applicable members had access to ob/gyns within these parameters. Over 95% of members had access to specialists within 60 miles. All members had access to most specialists within 90 miles, except for access to dermatologists and endocrinologists. The MCO discusses this issue in their annual network plan and gap analysis. They have entered into value based payment arrangements to incent additional specialist to join their network. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
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	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports	Substantial	This requirement is addressed in the NPDMP on page 14. Not all members in urban and rural parishes had access to radiology services within 20 and 30 miles, respectively.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	parishes.	Requests for exceptions		Not all members in urban and rural parishes had access to lab services within 20 and 30 miles, respectively. Lab services are a challenge that the MCO addresses through negotiating for additional access points through Quest and LabCorp. Some providers and national and do not reflect as providers on their GeoAccess reports even though they are providing services to members in LA. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1 Travel distance shall not exceed 10 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the NPDMP on page 14. Not all members in urban parishes (97%) had access to pharmacies within 10 miles. All members in rural parishes had access to pharmacies within 30 miles. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1 Travel distance shall not exceed 10 miles in urban areas; and .2 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for	Substantial	This requirement is addressed in the NPDMP on page 15. Not all members in urban and rural parishes had access to hemodialysis centers within 10 and 30 miles, respectively. About one-fifth of urban	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		exceptions		members and more than one-third of rural members did not have access to hemodialysis centers within these parameters. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission/appointment maximum time is addressed in the Access to Care Plan on page 8. None of the members in urban or rural parishes had access to ASAM Level 3.3 services within 30 miles or 90 minutes. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8. Fewer than 60% of adult and adolescent members had access to ASAM Level 3.5 services within the indicated parameters. Only 13.9% of adolescent members had access to ASAM Level 3.5 services within 60 miles or 90 minutes.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should continue to enroll providers to ensure it meets the access requirements.	
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8. Fewer than 30% of members in urban and rural parishes had access to ASAM Level 3.7 services within 60 miles or 90 minutes. For urban parishes the access rate was 16.8% and for rural parishes it was 27.1%. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8, except for withdrawal management (24-hour) requirement. Fewer than 90% of adult members in urban and rural parishes had access to ASAM Level 3.7WM services. For urban parishes the access rate was 16.8% and for rural parishes it was 27.1%. **Recommendation** The MCO should continue to enroll	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				providers to ensure it meets the access requirements.	
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	The distance and time requirements are addressed in the NPDMP on pages 19 and 46. The admission and appointment maximum time is not addressed in any policy. Not all members had access to PRTFs within 200 miles or 3.5 hours. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements. We have been working with an organization that has 3 locations in the state in hopes of contracting with them. We will continue our efforts with them! We are also in discussions with an out of state facility for potential contracting, if the need arises. They are in a contiguous state.
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	Policy for Provider Network	Substantial	This requirement is not addressed in any of the policies submitted for review. However, the RCA contract evidences the implementation of this requirement on page 4. **Recommendation** The MCO should include this requirement in its policies regarding provider network.	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO	Provider contracts Provider Handbook/Manual	Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16.	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.			**Recommendation** The MCO should include this requirement in its policies regarding provider network	
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, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider contracts Provider Handbook/Manual Member Handbook	Substantial	This requirement is partially addressed in the NPDMP on page 73; however, the specifics of this requirement, for example income status and cognitive disability, are not included in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts Provider Handbook/Manual	Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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,	Provider contracts Provider Handbook/Manual	Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation**	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	other public or private patients, or the public at large.			The MCO should include this requirement in its policies regarding provider network	
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.	Provider contracts Provider Handbook/Manual	Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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 the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	Policy for Provider Network Policy for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider types	Substantial	This requirement is addressed in the NPDMP on page 21 and evidenced by the GeoAccess reports. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	The MCO will continue outreaching to providers in an effort of enrollment and contracting in multiple areas and with various provider types and specialties to meet our members needs.
7.8.14.12	The MCO shall report the number of out-of-state	Policy for provider network	Substantial	This requirement is not included in any policy provided by the MCO.	We accept this recommendation and will

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	Policy for care coordination		The monthly behavioral health out-of-state reports evidence the implementation of this requirement. **Recommendation** The MCO should include this language in their policies and procedures.	ensure our policies are updated appropriately.
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Tracking report Policy for service coordination	Minimal	The MCO provided the network development plan in support of this requirement, however the required language was not found. The MCO states that no suspensions or terminations occurred during the review period that would trigger the reporting requirements contained in this element. **Recommendation** The MCO should include the required language in their policies and procedures.	We accept this recommendation and will ensure our policies are updated appropriately.
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it	Policy for credentialing & recredentialing	Substantial	This requirement is addressed in the Credentialing Policy and Procedure Development Amendment on page 1; however, the timeliness requirement is not included in this policy. The requirement is also addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period on May 2019. As such, the timeliness requirement is not	We accept this recommendation and will ensure the policy is updated appropriately.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.			included in any policy submitted for review. **Recommendation** The MCO should include the timeliness requirement in their policies.	
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body,	Policy for provider contracting	Substantial	This requirement is addressed in the Non-Traditional Provider Credentialing Policy on pages 2 and 3; however, this language was added after the review period on May 2019. **Recommendation** The MCO should finalize the Non-Traditional Provider Credentialing Policy to include this requirement for review in the next cycle.	We accept this recommendation and will ensure the policy is finalized with the appropriate language.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).				
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	Policy for credentialing & recredentialing	Substantial	This requirement is not addressed in any of the policies submitted for review. The RCA contract evidences the implementation of this requirement on page 19.	We accept this recommendation and will update our policies accordingly.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should include this requirement regarding credentialing of specialized BH providers in its credentialing and recredentialing policies.	
7.14.9	The MCO shall notify LDH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	Policy for credentialing & recredentialing	Substantial	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period in May 2019. The RCA contract states that the subcontractor will notify MCO, not LDH, on page 19. **Recommendation** The MCO should finalize the Practitioner Credentialing, Recredentialing Policy to include this requirement for review in the next cycle.	We will ensure the policies are updated appropriately.
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	Policy for credentialing & recredentialing	Substantial	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period in May 2019. The RCA contract evidences the implementation of this requirement on page 19. **Recredentialing File Review Results** Five (5) of five (5) files were completed for recredentialing within three years.	We will ensure the policy is finalized with the updated language.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should finalize the Practitioner Credentialing, Recredentialing Policy for review in the next cycle.	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	Policy for credentialing & recredentialing	Substantial	This requirement is not addressed in any of the policies submitted for review. The MCO does have policies and procedures for approval of providers, and termination or suspension of providers that evidence the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	We will update our policies to ensure the requirement language is added in accordance with our practice of the requirement.
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	Policy for credentialing & recredentialing Policy for provider dispute and appeal process Documented provider dispute and resolution process for sanctions, suspensions and terminations Evidence of timely process submission	Substantial	This requirement is not addressed in any of the policies submitted for review. However, the MCO does have policies and processes for provider dispute (Provider Dispute Resolution Policy), provider complaints (Provider Complaints Policy), provider appeals (Provider Appeals Policy), and sanctions and terminations (Provider Network Voluntary and Involuntary Terminations Policy) that evidence the implementation of this requirement. During onsite interviews, The MCO described how provider grievances go through their regular queue process. Non claims disputes such as quality of care issues go out to the relevant team. There are different entry points for issues based on type, i.e., grievance v	We will update our policies to ensure the requirement language is added in accordance with our practice of the requirement.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				compliance, etc. **<u>Recommendation</u>** The MCO should include this requirement in its policies.	
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts Member Handbook	Substantial	This requirement is not addressed in any of the policies submitted for review. The RCA contract partially evidences the implementation of this requirement on page 7; however, does not explicitly indicate "information disclosure requirements related to physician incentive plans." **<u>Recommendation</u>** The MCO should include this requirement in its policies.	We accept the recommendation and will update our policies accordingly.
Utilization Management					
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to LDH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	Policy for UM Evidence of timely submission of Policy for UM	Substantial	This requirement is partially addressed in the Prior Authorization Policy, page 12 and the Concurrent Review/OBS Care Policy, pages 6-7. The MCO states that policies for 2019 were reviewed and submitted to LDH on 6/2/19. There was no evidence of transmission provided, and furthermore, there was no evidence that policies from 2018 (9/12 months of the review period) were submitted to LDH. During the interview on-site, the MCO stated that despite having updated their policy, they did not recall sending the	

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				updated policy to LDH. **Recommendation** The MCO should ensure that UM policies and procedures are submitted to LDH for timely approval.	
Eligibility, Enrollment, and Disenrollment					
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).	Policy for Member Disenrollment	Substantial	This requirement is addressed partly in the Member Disenrollment/Disruptive Member Transfer Policy on page 3. The second (90 days following the postmark) and last (sanctions) subparts of this requirement are not addressed in this policy. The former subpart is included in the member handbook on page 50; however, the latter (sanctions) is not. **Recommendation** The MCO should include all reasons for disenrollment without cause in the Member Disenrollment/Disruptive Member Transfer Policy and the member handbook, as appropriate.	11.11.3.2
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member	Policy for Member Disenrollment	Non-compliance	This requirement was not addressed in any policy or document provided by the MCO. The Member Disenrollment/	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	can appeal directly to the State Fair Hearing process.			Disruptive Member Transfer Policy does not mention the state fair hearing process. The member handbook does not include this requirement. This requirement was discussed during onsite interviews, and the MCO provided an amended Member Disenrollment/ Disruptive Member Transfer policy with this language added. This amended policy is dated 08/09/2019, which is after the review period. **Recommendation** The MCO should finalize the Member Disenrollment/ Disruptive Member Transfer Policy to include this requirement for the next review period.	
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts	Policy for Member Disenrollment Member Notification Letter	Substantial	This requirement is partially addressed in the Member Disenrollment/ Disruptive Member Transfer Policy on pages 4 and 5. The language in the policy does not include pre-existing medical condition, refusal of medical care or diagnostic testing, and attempts to exercise member's right to change PCPs. **Recommendation** The MCO should include in their policies that disenrollment will not be requested due to member's pre-existing medical condition, member's refusal of medical care or diagnostic testing, or member's attempts to change, for cause, their PCP.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).				
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	Policy for Member Disenrollment Member Notification Letter	Substantial	The requirement that the MCO shall notify the member in writing and that notification includes reason for disenrollment request is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 5. That the notification should include the effective date is not included in this policy. **Recommendation** The MCO should include the requirement that these notification letters should include the effective date in their policy.	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	Policy for Member Disenrollment	Minimal	This requirement is not entirely or explicitly addressed in any policy provided by the MCO. That the disenrollment actions will be coordinated only through the broker is indicated in the Member Disenrollment/Disruptive Member Transfer Policy on page 1; however, the information that should be included and that the form should be used are not included in this policy. **Recommendation** The MCO should include this requirement with all its subparts in a policy.	
11.11.4.6	The MCO shall not submit a disenrollment request at such a	Policy for Member Disenrollment	Substantial	This requirement is addressed verbatim in the Member Disenrollment/Disruptive	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.			Member Transfer Policy on pages 6 and 7; however, this language was inserted into the policy on 5/21/2019, which is outside the review period. **Recommendation** The MCO should finalize the Member Disenrollment/Disruptive Member Transfer Policy to include this requirement for the next review period.	
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	Policy for Member Disenrollment	Substantial	This requirement is not addressed explicitly in any policy submitted by the MCO. On page 4, the Member Disenrollment/Disruptive Member Transfer states, "Aetna Better Health business application system does not process the disenrollment until the Department sends the disenrollment record on the enrollment file," which implies that the MCO is responsible for the provision of all core benefits and services to the member until the member is disenrolled by enrollment broker. This requirement was discussed during onsite interviews, and the MCO provided an amended Member Disenrollment/ Disruptive Member Transfer policy with this language added. This amended policy is dated 08/2019, which is after the review period. **Recommendation** The MCO should finalize the Member Disenrollment/Disruptive Member	

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				Transfer Policy to include this requirement for the next review period.	
Marketing and Member Education					
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: • Flesch – Kincaid; • Fry Readability Index; • PROSE The Readability Analyst (software developed by Educational Activities, Inc.); • Gunning FOG Index; • McLaughlin SMOG Index; or • Other computer generated readability indices accepted by LDH.	P/P for Written Member Materials Guidelines Sample written member materials	Substantial	This requirement is substantially addressed in the Member Materials Standards Policy on page 2. However, this policy does not explain how the reading level is determined. Nor does it include that technical terms will be explained to members. During the previous review, the MCO was advised to incorporate these into their policies. The member handbook explains key healthcare terms on pages 56 to 58. **Recommendation** The MCO should include in their policies how reading level of member materials is determined and that technical terms will be explained to members.	
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Minimal	That written materials should be "presented in a format that enhances understanding" is addressed in the Member Materials Standards Policy on page 2; however, the specifics of this requirement are not included in this policy (i.e., minimum font size.)	**MCO Response** The MCO provided the New, Existing and Reinstated Member Information policy dated 02/01/2015 on page 3; however, this required language was added after the review period, according

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				The member materials provided for review by the MCO (member handbook, etc.) have 10pt or larger font. **Recommendation** The MCO should include the minimum font size requirements for member materials (with the exception of ID cards) in their policies.	to the redline changes and revision history on page 10.
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Substantial	This requirement is addressed in the draft of the Print and Mailing Policy on page 3; however, the language pertaining to this requirement was inserted into this policy on 5/31/2019, after the review period. **Recommendation** The MCO should finalize the draft of the Print and Mailing Policy to include this requirement.	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	P/P for Written Member Materials Guidelines Sample written member materials	Substantial	This requirement is addressed in the draft Print and Mailing Policy submitted by the MCO; however, this language was added to the policy on 6/3/2019, which is after the review period. The MCO provided the 2018 Annual Notice to Members, which is a multi-page document. The MCO name and toll-free number are visible on the front page; however, the mailing address is not displayed anywhere on the document.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				The member handbook displays the MCO's name and website on the front and back covers; however, the mailing address and the toll free number are not displayed on the covers. The mailing address and the toll free number are listed inside the member handbook, which does not meet this requirement. **Recommendation** The MCO should finalize the Print and Mailing Policy with required language and implement this requirement for all multi-page marketing materials, including the member handbook.	
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal	Minimal	This requirement is not addressed in any of the policies provided by the MCO. The member portal can be reached at https://www.aetnabetterhealth.com/louisiana/members/portal and provides a link to the secure member portal. The mobile app for smart phones is available and members are informed of this on the "For Enrollees" page of the website. **Recommendation** The MCO should include this requirement in its policies.	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Example of bullets/news letter	Minimal	This requirement is not addressed in any of the policies provided by the MCO. The Spring 2018 and Summer 2018 Newsletters evidence the implementation of this requirement. **Recommendation** The MCO should include this	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				requirement in its policies.	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Brochures and other examples of literature including EPSTD materials	Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The growth chart and swim lessons flyer provided by the MCO for review evidence the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN	Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a diabetes pamphlet, which evidences the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials	Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a swim lessons flyer, which evidences the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications	Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a swim lessons flyer to evidence the implementation of this policy.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should include this requirement in its policies.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material	Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a diabetes education empowerment (DEEP) class flyer to evidence the implementation of this policy. **Recommendation** The MCO should include this requirement in its policies.	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Example Member education material	Non-compliance	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided the Spring/Summer 2019 asthma flyer to evidence the implementation of this policy; however, this was outside the review period. **Recommendation** The MCO should include this requirement in its policies.	
12.12.1.38	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	Member notification	Minimal	This requirement is not addressed in any policy provided by the MCO. However, the 2018 Annual Notification to Members evidences the implementation of this requirement. The Member Rights and Responsibilities policy states on pages 5-6, "Each subsequent year members are notified of member rights and responsibilities and any changes through the Aetna Better Health website, annual notification and	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				member newsletter."..." Aetna Better Health informs members, providers/practitioners about the availability of member rights and responsibilities documentation online and about the various methods available to contact Aetna Better Health for assistance. If information is posted on the website, Aetna Better Health informs members and practitioners that the information is available online. Information is mailed to members and providers/practitioners who do not have fax, e-mail or internet access." This does not address the requirement because it does not reference either the Member Handbook or the member Welcome Newsletter, but only rights and responsibilities documentation. **Recommendation** The MCO should include this requirement in their policies about member handbook or welcome newsletter.	
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook	Substantial	The requirement that the member handbook will be updated at least once a year is addressed in the member handbook on page 11. The requirement that the handbook must be submitted for approval to LDH is addressed in the Member Communications Policy on page 3; however, the timeliness requirement (four weeks) is not included. Date of revision is listed as "effective	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				date" on page 1 of the member handbook (September 1, 2018). The MCO provided the New, Existing and Reinstated Member Information policy dated 02/01/2015 on page 3; however, this required language was added after the review period, according to the redline changes and revision history on page 10. **Recommendation** The MCO should finalize the draft of the New, Existing and Reinstated Member Information policy to include this requirement.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)	Substantial	This requirement is mostly addressed in the Provider Directory Updates Policy on page 3; however, that the provider directory online should be "web-based machine readable" is not included in the policy. In the same policy, on page 9, usability testing is addressed, but not for machine readability. The provider directory is online and searchable by members and by the public at https://www.aetnabetterhealth.com/louisiana/members/directory. The MCO provided the Aetna Better Health of Louisiana Website - Provider Search Usability Report. **Recommendation**	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				The MCO should include this requirement in its entirety in its policies.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	P/P for Provider Directory Provider Directory (abbreviated hard copy)	Substantial	This requirement is addressed in the Provider Directory Updates Policy on page 3. During onsite discussion, the MCO indicated there is no abbreviated version available. **Recommendation** The MCO should make an abbreviated version of the provider directory available.	
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities,	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial	This requirement is addressed in the Provider Directory Updates Policy on page 10. The cultural competency training part of the requirement is addressed on page 5. However, the online provider search does not include information about provider's cultural competency training status. **Recommendation** The MCO should include this information in its online provider search.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	including offices, exam room(s) and equipment;				
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	P/P for Provider Termination P/P for notifying members of provider termination	Substantial	This requirement is partially addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 4 and 10. However, that the notice shall be provided within seven (7) days is not included with regards to prior authorized course of treatment. **Recommendation** The MCO should include the timeliness requirement in its policy.	
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member	P/P for oral and written interpretation services P/P for notification of member of	Substantial	This requirement is addressed in the Interpreter and Translation Services Policy on page 5; however, the percentage indicated in the policy is 5%,	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c)(4) and (5).	interpretation services and how to access the services		not 4%. During onsite discussion, the MCO indicated that an amended policy is currently going through approval. **Recommendation** The MCO should finalize the draft of the Interpreter and Translation Services Policy to include this requirement.	
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit.	P/P for Member Rights and Responsibilities	Substantial	This requirement is addressed in the Interpreter and Translation Services Policy on pages 7 and 8 and in the Member Materials Standards Policy on page 2; however, the font size requirement (18 point) for large print materials is not included in any policy submitted for review. The member handbook includes taglines in 16 languages regarding multi-language interpretation services free of charge to the member on page 61. **Recommendation** The MCO should include this font size requirement in their Member Materials Standards Policy.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Large print means printed in a font size no smaller than 18 point.				
Member Grievance and Appeals					
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	P/P for Notice of Action Notice of Action Includes Member Appeal File Review	Substantial	This requirement is addressed in policy LA 3100.70 Member Appeals **<u>File Review Results</u>** **Appeals Files** Two (2) of the Ten (10) files reviewed were resolved in the members favor and therefore were Not Applicable Eight (8) of Eight (8) remaining files did not meet the requirement Onsite it was discussed that Aetna's notice after initial prior authorization review does contain the language however the appeal letter does not. **<u>Recommendation</u>** Aetna should add the explicit instructions on accessing continuous benefits during the State Fair Hearing process to the notice of adverse benefit determination.	
13.5.2.8	Availability of interpretation services for all languages and how to access them.	P/P for Notice of Action Notice of Action	Substantial	Aetna indicated that the required language could be found in Policy 3100.70 Member Appeals, page 7. A full review of this policy revealed "oral interpretation services and alternate formats will be available to members at no cost". On the other hand the section of the policy directly related to the notice of action or decision letter does	

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
				not mention inclusion of this service as a standard disclosure. **Recommendation** The language describing the availability of interpretation services should be included in the Notice of Action.	
13.5.3.2	In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud at least five (5) days before the date of action;	P/P for Notice of Action	Non compliance	This new language is not yet included in policy LA 3100.70 Member Appeals Onsite, Aetna stated that the requirement is addressed in policy. LA 0041. LA State notification. A review of this policy did not indicate that the required language was contained within. **Recommendation** Aetna should add the required language to its policies and procedures.	
Quality Management					
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan	Substantial	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. A pre-onsite review of the annual 17P measure, as well-as the monthly ITM measures identified variance in monthly versus annual denominators of high risk pregnant women with prior preterm birth. Aetna states the following: "There are historical issues with rate calculation. This is a state measure. Aetna's QI Department did an audit of	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				17P calculation. Modifications to the logic have been made. Going forward, Aetna is using the Inovalon HEDIS product to eliminate this variance." **Recommendation** Aetna should move forward with its remediated process and monitor this measure to ensure rate accuracy.	
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to LDH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO members and providers; • The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and	PIP proposal/reports P/P performance input projects PIP meeting minutes	Substantial	With the exception of the IET PIP, Aetna has met all PIP requirements. During the review period, there were two IET PIP components with a determination of Not Met: 2c. Objectives did not align aim and goals with interventions, and 4a. Susceptible subpopulations were not identified using claims data on performance measures, and Stratified by demographic and clinical characteristics. Also during the review period, there was no primary contact person indicated on the IET PIP. **Recommendation** Aetna should address these issues in their next PIP submission.	

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.				
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council	Substantial	This requirement is addressed in the Member Advisory Committee charter. Aetna provided QAPI meeting minutes that reference the MAC and states that minutes were not kept. **Recommendation** Aetna should keep minutes of its MAC meetings.	
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Member Advisory Council Plan	Substantial	This requirement is addressed in The Member Advisory Committee charter. Aetna provided QAPI meeting minutes that reference the MAC and states that training materials or training agendas are available. **Recommendation** Aetna should conduct required training and document attendance by MAC members.	
14.5.6.	LDH shall be included in all correspondence to the Council, including agenda and Council	Member Advisory Council Plan	Substantial	This requirement is addressed in the Member Advisory Committee charter.	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.			Aetna provided QAPI meeting minutes that reference the MAC and states that minutes were not posted. **Recommendation** Aetna should keep and post minutes of its MAC meetings.	

MCO Final Audit Tools

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

Core Benefits and Services

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.4	**Behavioral Health Services**					
6.4.5 6.4.5.1	**Permanent Supportive Housing** LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid Managed Care members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388 Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. For the Louisiana PSH program, the MCO shall:					
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member letters Member handbook Policy for member		Full	This requirement is addressed in the PHS Desktop document and PSH Outreach document.	

Core Benefits and Services						
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		education				
6.4.5.1.2	Assist members in completing the PSH program application;	Member letters Member handbook Policy for member education		Full	This requirement is addressed in the PHS Desktop document and PSH Outreach document.	
6.4.5.1.3	Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	Communications to LDH Policy for education		Full	This requirement is addressed in the email communication that was provided.	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and	Completed LDH template		Full	This requirement is addressed in the email communication that was provided, as well as the PSH Outreach spreadsheet.	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:					
6.4.5.2.1	Identify a PSH program liaison, to be approved by LDH, to work with LDH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Organizational chart		Full	This requirement is addressed by the job description and document that identified the current PSH program liaison.	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.	Training slides Policy for provider education Provider handbook		Full	This requirement is addressed in the provider manual and in the Provider Relations Functions & Responsibilities Training provided after the review.	
6.4.9.1	The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider handbook Provider education materials Provider contracts Policy for provider education		Full	This requirement is addressed in the Provider Relations Department Functions and Responsibilities Policy, provider manual, training document, and ADHD project document.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	Policy for provider education Provider handbook		Full	This requirement is addressed in the provider manual and the Provider Relations Department Functions and Responsibilities Policy.	
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	Policy for behavioral integration Communications with community agencies		Full	This requirement is addressed in the policy A-LA 7000.50 Supporting Members in Crisis and in correspondence provided after the review evidencing communication with community agencies.	
6.8	**Emergency Medical Services and Post Stabilization Services**					
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the	Member handbook Policy for ER services		Full	This requirement is addressed in the member handbook and policies provided.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.					
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member handbook		Full	This requirement is addressed in the member handbook.	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Member handbook Policy for Member services		Full	This requirement is addressed in the member handbook.	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	Member handbook Policy for emergency services		Full	This requirement is addressed in the member handbook and the Prior Authorization Policy.	
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	Provider handbook Policy for Care coordination		Full	This requirement is addressed in the Prior Authorization Policy and in the provider handbook.	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	Policy for Coordination of services Communications to hospital		Full	This requirement is addressed in the Prior Authorization Policy. Additionally, the MCO was able to clarify during the interview on-site that this type of disagreement would not occur in practice due to the MCO getting notified after claims data had been processed, and that they would not challenge a treating facility.	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-	Policy for Coordination of Services		Full	This requirement is addressed in the ED Diversion Workplan document, member	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to LDH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	Quality of core plan Member handbook			handbook, as well as the Coordination of Member Care Policy.	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member & provider handbook Educational materials		Full	This requirement is addressed in the provider manual and member handbook.	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.	P./P Emergency services Member handbook		Full	This requirement is addressed in the Prior Authorization Policy and member handbook.	
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member handbook		Full	This requirement is addressed in the member handbook.	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:					
6.8.2.1.1	Pre-approved by a network provider or other MCO	P./P post stabilization		Full	This requirement is addressed in the Prior	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	representative; or	services			Authorization Policy.	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.	P./P post stabilization services Provider handbook		Full	This requirement is addressed in the Prior Authorization Policy and provider handbook.	
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	P./P post stabilization services				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.8.2.2.4	The member is discharged.	P./P post stabilization services		Full	This requirement is addressed in the Prior Authorization Policy.	
6.19	**Services for Special Populations**					

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:					
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;					
6.19.1.2	Individuals with intravenous drug use;					
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;					
6.19.1.4	Individuals with substance use disorders who have dependent children;					
6.19.1.5	Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;					
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;					
6.19.1.7	Adults, 18 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter or are transitioning out of the CSoC program.					
6.19.1.8	Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;					
6.19.1.9	Individuals with co-occurring behavioral health					

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and developmental disabilities;					
6.19.1.10	Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;					
6.19.1.11	Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and					
6.19.1.12	Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.					
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.	HRA Policy for members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the PQ039 Report and the Integrated Care Management Policy. **File Review Results** Ten (10) of 10 case management files met the requirement for an individual needs and diagnostic assessment within 90 days of identification of need. Ten (10) of 10 behavioral health case management files documented contact with the Integrated Medicaid Managed Care Program Plan Care manager. Ten (10) of 10 files met the requirement for an individual needs assessment.	
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: .1 The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet	Policy for members with Special Health Needs Documentation of assessment conducted Includes Case Management		Full	This requirement is addressed by the PQ039 report and the Integrated Care Management Policy. **File Review Results** None (0) of the 10 case management files had a documented referral source of Special	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	MCO, LDH approved, guidelines for SHCN criteria. .2 MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. .3 Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. .4 Members may be identified by LDH and that information provided to the MCO.	File Review			Health Care Needs (SHCN). None (0) of the 10 behavioral health case management files were applicable to the SHCN requirement.	
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager. The individualized treatment plans must be:	Policy for Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review		Full	This requirement is addressed in the PQ039 Report and the Integrated Care Management Policy. **File Review Results** Ten (10) of the 10 case management files had an individual care plan based on the needs assessment, and 10 of the 10 files included short and long term care goals in their care plans. Ten (10) of the 10 files had plans of care developed with member and/or family involvement. Ten (10) of 10 behavioral health case management files had a care plan based upon the member's individual needs assessment, that was developed with the involvement of the member/family, and included short and long term member goals. Ten (10) of 10 files included a care plan that documented member demographics and supports and services. Five (5) of 5 applicable files met the requirement for crisis planning.	
6.19.4.1	Developed by the member's primary care provider	Treatment plan		Full	This requirement is addressed in the	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Policy for Individual Treatment Plans Documentation of communication Includes Case Management File Review			Integrated Care Management Policy.	
6.19.4.2	In compliance with applicable quality assurance and utilization management standards:	Policy for Individual Treatment Plans				
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	Policy for Individual Treatment Plans Plan of Care Includes Case Management File Review		Full	This requirement is addressed in the Integrated Care Management Policy. **File Review Results** Eight (8) of 8 applicable case management files met the requirement for ongoing care plan review. Although 2 files lacked sufficient timeframes for care plan follow-up review, the monitoring of outcomes was documented for all 10 files. Seven (7) of 7 applicable files met the requirement for treatment revision. Ten (10) of 10 behavioral health case management files documented monitoring of outcomes. Eight (8) of 8 applicable behavioral health case management files documented revision of the care plan as necessary.	

Core Benefits and Services						
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6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.	Policy for Individual Treatment Plans Plan of Care		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.28	**Care Management**					
6.28.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	CM records Member Handbook		Full	This requirement is addressed in the member handbook and Member Care Coordination Policy.	
6.28.2 6.28.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	Policy for member Services Provider handbook Includes Care Management File Review	-	Full	This requirement is addressed in the member handbook and Member Care Coordination Policy. **File Review Results** Ten (10) of 10 case management files contained documentation that prevention and treatment services are accessible and comprehensive. Ten (10) of 10 case management files met the requirement for referrals as indicated. Nine (9) of 9 applicable behavioral health case management files met the requirement for recording the member's PCP in the care	

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					management record or otherwise follow-up.	
6.28.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	Policy for member Services Call center documentation		Full	This requirement is addressed by the member handbook. Additionally, during the interview portion of the review, the MCO clarified that if a member needs to reach a CM afterhours, there is a main telephone number that is fielded by a representative. There is a CM available afterhours that can address issues, if needed. The MCO is also flagged for calls of this nature, and notified of all outcomes. There is also a local field CM team that can triage, if needed.	
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	CM records Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Integrated Care Management Policy and Member Care Coordination Policy. **File Review Results** Ten (10) of 10 case management files met the requirement for ongoing care coordination, with initial coordination of activities with the Chronic Care Management Program documented for 9 of 9 applicable files. Ten (10) of 10 files had evidence of health care coordination. Nine (9) of 9 files met the requirement for referrals made when necessary. Ten (10) of the 10 behavioral health files met the requirement for coordination of activities with the Chronic Care Management Program. Nine (9) of the 9 applicable behavioral health files met the requirement for referrals when necessary. Contact was made with the Integrated Medicaid Managed care Program	

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					Plan Care Manager for all 10 of 10 files.	
6.28.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	Pain management plans Policy for care coordination		Full	This requirement is addressed in the Member Restriction Policy and pain management plan template provided after the review.	
6.30	**Care Coordination, Continuity of Care, and Care Transition**					
6.30.0	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 LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to LDH by January 11, 2016. 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 Thmonitored through	Policy for care coordination Policy for PCP choice Member survey Detailed Workflows		Full	This requirement is addressed by the Coordination of Member Care Policy, the Corrective Action Policy, the Transitions of Care Document, and the Interdisciplinary Care Team Activities Document.	

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	member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.					
6.30.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	Policy for care coordination		Full	This requirement is addressed in the Member Transition Policy and Coordination of Member Care Policy.	
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
6.30.2.1	Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) daytime period;	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Integrated Care Management Policy and Outreach and Enrollment Document. **File Review Results** Ten (10) of the 10 case management files met this requirement.	
6.30.2.2	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Member Transition Policy. **File Review Results** Ten (10) of the 10 behavioral health case management files met the requirement for an ongoing source of preventive and primary care. Ten (10) of the 10 files met the requirement regarding the release of information from the member/family obtained to coordinate care with the PCP and other healthcare providers.	

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6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed by the member handbook and Integrated Care Management Policy. **File Review Results** Ten (10) of 10 case management files met this requirement.	
6.30.2.4	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	Policy for care coordination		Full	This requirement is addressed in the Member Transition Policy.	
6.30.2.5	Coordinate care for out-of-network services, including specialty care services;	Policy for care coordination		Full	This requirement is addressed in the Member Transition Policy.	
6.30.2.6	Coordinate MCO provided services with services the member may receive from other health care providers;	Policy for care coordination		Full	This requirement is addressed in the Member Transition Policy.	
6.30.2.7	Upon request, share with LDH or 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;	Policy for care coordination		Full	This requirement is addressed in the Integrated Care Management Policy and Care Plan Development and Updating Document.	
6.30.2.8	Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;	Policy for care coordination Provider Handbook		Full	This requirement is addressed in the Member Transition Policy and the provider manual.	
6.30.2.9	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	Policy for care coordination		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.30.2.10	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Discharge Planning Policy and the Concurrent Review/Observation Care Policy.	
6.30.2.11	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments,	Policy for care coordination Includes Care Management		Full	This requirement is addressed in the Discharge Planning Policy and the Concurrent Review/Observation Care Policy.	

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	following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	File Review			**File Review Results** Ten (10) of 10 case management files met this requirement. Six (6) of 6 applicable behavioral case management files met the discharge planning requirement.	
6.30.2.11.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	Policy for care coordination		Full	This requirement is addressed in the Pharmacy Prior Authorization Policy.	
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	Policy for care coordination CM records		Full	This requirement is addressed in the Pharmacy Prior Authorization Policy.	
6.30.2.11.3.	Coordination with LDH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	Policy for care coordination		Full	This requirement is addressed within the policies provided.	
6.30.2.11.4	Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is	Policy for care coordination		Full	This requirement is addressed in the Discharge Planning Policy and the Concurrent Review/Observation Care Policy.	

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	contacted by and is receiving services from aftercare providers as per the member's discharge plan.					
6.30.2.12	Document authorized referrals in its utilization management system;	Policy for care coordination		Full	This requirement is addressed in the Prior Authorization Policy.	
6.30.2.13	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:	Policy for care coordination		Full	This requirement is addressed in the Member Transition Policy.	
6.30.2.14	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and	Policy care coordination Court proceedings		Full	This requirement is addressed in the Prior Authorization Policy, Concurrent Review Policy, and MCO Key Contact List document.	
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	Policy care coordination		Full	This requirement is addressed within the Discharge Planning Policy and Concurrent Review/Observation Care Policy.	
6.36	**Continuity for Behavioral Health Care**					
6.36.1	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.	Policy for BH care continuity Provider contract Provider manual/handbook		Full	This requirement is addressed in the provider handbook and Patient Centered Medical Home Policy, as well as on the MCO's website [https://www.aetnabetterhealth.com/louisiana/providers/bh].	
6.36.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that	Policy for BH care continuity		Full	This requirement is addressed in the Integrated Care Management Policy.	

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	guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.					
6.36.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Policy for BH care continuity Communication member		Full	This requirement is addressed in the member handbook and Integrated Care Management Policy.	
6.36.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	Policy for BH care continuity		Full	This requirement is addressed in the Prior Authorization Policy.	

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6.36.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	Policy for BH care continuity		Full	This requirement is addressed in the Coordination of Member Care Policy and Integrated Care Management Policy.	
6.36.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	Policy for BH care continuity		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.36.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.	Policy for BH care continuity		Full	This requirement is addressed in the Coordination of Member Care Policy.	
6.36.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	Policy for BH care continuity		Full	This requirement is addressed in the Coordination of Member Care Policy and CALOCUS Training.	
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3 6.36.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder;	Policy for BH care coordination		Full	This requirement is addressed in the Integrated Care Management Policy	

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	• Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co- management.					
6.36.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	Policy for provider contracting Provider contracts		Full	This requirement is addressed in the PCMH Policy. The MCO provided additional documentation of this requirement after the review within trainings to providers that took place in 2018.	
6.36.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Provider portal/handbook Training materials		Full	This requirement is addressed: the provider relations orientation.	
6.36.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	Member/provider handbook Educational materials		Full	This requirement is addressed in the member handbook and provider manual.	
6.36.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	Policy for coordination of care		Full	This requirement is addressed in the ER Diversion Workplan document and the screenshot of Care Unify Data.	
6.36.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	Policy for coordination of care		Full	This requirement is addressed in the Coordination of Member Care Policy and the Integrated Care Management Policy.	
6.36.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Clinical management system records		Full	This requirement is addressed in the Integrated Care Management Policy and screenshot of the clinical management system records.	
6.36.9.1.11	Developing capacity for enhanced rates or	Policy for provider		Full	This requirement is addressed in the Patient	

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	incentives for integrated care by providers;	initiatives			Centered Medical Home Policy.	
6.36.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Training materials Provider handbook		Full	This requirement is addressed in the CALOCUS training document and provider handbook.	
6.36.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CM rounds minutes/schedule		Full	This requirement is addressed in the Integrated Care Management Policy and integrated round email provided.	
6.36.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.	Meeting minutes		Full	This requirement is addressed in the scheduled meeting invitation that was provided.	
6.40	**Case Management (CM) Policies and Procedures**					
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH 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:	Policy for CM		Full	This requirement is addressed in the 040 ABH 2018 Annual Report.	
6.40.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.40.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.40.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.	Policy for CM		Full	This requirement is addressed by the Integrated Care Management Policy.	
6.40.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as	Policy for CM Treatment plan template		Full	This requirement is addressed in the Integrated Care Management Policy.	

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	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;					
6.40.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.40.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.40.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	Policy for CM		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.41	**Case Management Reporting Requirements**					
6.41	The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Evidence of Communication to LDH		Full	This requirement is addressed in the communication to LDH email provided.	
6.41.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	
6.41.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	
6.41.3	Number of members identified with potential special healthcare needs that self- refer;	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	

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6.41.4	Number of members with potential special healthcare needs identified by the MCO;	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports		Full	This requirement is addressed in the 165 Report that was provided.	
6.41.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	CM/Special health Care needs reports		Full	This requirement is addressed in the 317 Report that was provided.	
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	
6.41.8	Number of members with assessments resulting in a referral for Case Management.	CM/Special health Care needs reports		Full	This requirement is addressed in the 039 Report that was provided.	
6.42	**Chronic Care Management Program (CCMP)**					
6.42.1	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.	Policy for CCMP CCMP descriptions		Full	This requirement is addressed within the Integrated Care Management Policy and documents provided.	
6.42.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to LDH.	Policy for CCMP CCMP descriptions		Full	This requirement is addressed within the Integrated Care Management Policy and 039 Report provided.	
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH 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:	Policy for CCMP CCMP descriptions		Full	This requirement is addressed by the 040 Report provided and the Integrated Care Management Policy.	

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6.42.4.1	Include the definition of the target population;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.2	Include member identification strategies, i.e. through encounter data;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed by the ICM Program Description Document and Integrated Care Management Policy.	
6.42.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed by the ICM Program Description Document and Integrated Care Management Policy.	
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed by the ICM Program Description Document and Integrated Care Management Policy.	
6.42.4.6	Include methods for informing and educating members and providers;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.8	Address co-morbidities through a whole-person approach;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.9	Identify members who require in-person case management services and a plan to meet this need;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy and ICM Program Description.	
6.42.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.42.4.11	Include Program Evaluation requirements.	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Integrated Care Management Policy.	
6.44	**CCMP Reporting Requirements**					
6.44.1	The MCO shall submit Chronic Care Management reports quarterly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Communications to LDH		Full	This requirement is addressed by the submitted screenshots of email uploads.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports		Full	This requirement is addressed in the 039 Report.	
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports		Full	This requirement is addressed in the 039 Report.	
6.44.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	CCMC reports		Full	This requirement is addressed in the 039 Report.	
6.44.3 6.44.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	CCMC reports		Full	This requirement is addressed in the Medical Management 2018 Evaluation Report.	

Provider Network Requirements

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**					
7.1.1	The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.					
7.1.2	The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the Network Provider Development and Management Plan (NPDMP) on page 2.	
7.1.3	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.	Network Provider Development and Management Plan Policy for Provider Network Policy for Access and Availability		Full	This requirement is addressed in the NPDMP on page 3.	
7.1.4	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 the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan Policy for Provider Network Policy for Access and Availability		Full	This requirement is addressed in the NPDMP on page 3.	
7.1.5	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)].	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan on page 6, in the provider manual on page 30 and in the NPDMP on page 8.	
7.1.7	The MCO's network providers shall ensure	Policy for Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	Policy for Access and Availability			provider manual on pages 35 to 37.	
7.1.8	At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.	Policy for Provider Network Policy for Access and Availability		Full	This requirement is addressed in the NPDMP on page 8 and in the Member Rights and Responsibilities Policy on page 4.	
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least	Network Provider Development and Management Plan Policy for Provider Network Provider manual/handbook Provider contracts		Full	This requirement is addressed throughout the NPDMP, most significantly on pages 29, 33, 74, 85 and 92. The provider manual addressed the cultural competency and language requirements on pages 35 to 37. The Louisiana Medicaid Regulatory Compliance Addendum (Provider) addresses this requirement on pages 14 and 15, which evidences the implementation of this requirement.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.2	**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. LDH will monitor the MCO's compliance with these standards through regular reporting as shown in Provider Network Companion Guide. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:					
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Access to Care Plan Policy on pages 6 to 8, in the provider manual on pages 22 and 52, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes information about 24 hours/7 days of behavioral health care, including the BH crisis line on page 29.	
7.2.1.2	Urgent Care within twenty-four (24) hours.	Policy for Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook			Access to Care Plan Policy on pages 6 to 8, in the provider manual on pages 22 and 52, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes information about 24 hours/7 days of behavioral health care, including the BH crisis line on page 29.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Access to Care Plan Policy on page 7, in the provider manual on page 23, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes about non-urgent sick care on page 40.	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Access to Care Plan Policy on page 7, in the provider manual on page 23, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes information about non-urgent sick care appointment timeframe on page 40.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Access to Care Plan Policy on page 7, in the provider manual on page 23, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes information about specialty care appointment timeframe on page 42.	
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 23, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 7. The member handbook includes	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		Member Handbook			information about lab and x-ray service appointment timeframe on page 42.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Access to Care Plan Policy on page 8, in the provider manual on page 23, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 6. The member handbook includes information about maternity care appointment timeframe on page 42.	
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the provider manual on page 24, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 7.	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be	Policy for Provider Network Policy for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the provider manual on page 24, and in the Louisiana Medicaid Regulatory Compliance Addendum (Provider) on page 7.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	available through a toll-free telephone number at all times.					
7.3	**Geographic Access Requirements**					
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the NPDMP on page 28. GeoAccess reports for the review period for physical and behavioral health evidence the implementation of this requirement.	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .3 Travel distance for members living in rural parishes shall not exceed 30 miles; and .4 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on page 12. Per Geo Access reports the member ratios meet the standard met in the Provider Network Companion Guide. Not all adult members in urban parishes had access to PCPs within 10 miles. All adult members in rural parishes had access to PCPs within 30 miles. Only 75% pediatric members in urban and 98% of rural parishes had access to PCPs within 10 and 30 miles, respectively. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
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.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on page 12. Not all members living in urban or rural parishes had access to acute inpatient hospitals within 10 and 30 miles, respectively. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
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 the Provider Network Companion Guide.. LDH 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 LDH for this purpose.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on pages 16 and 17. Access criteria for ob/gyns in urban parishes are 15 miles/30 minutes and in rural parishes are 30 miles/60 minutes, as indicated in the Provider Network Companion Guide. Not all applicable members had access to ob/gyns within these parameters. Over 95% of members had access to specialists within 60 miles. All members had access to most specialists within 90 miles, except for access to dermatologists and endocrinologists. The MCO discusses this issue in their annual network plan and gap analysis. They have entered into value based payment arrangements to incent additional specialist to join their network.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
					Recommendation The MCO should continue to enroll providers to ensure it meets the access requirements.	
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.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on page 14. Not all members in urban and rural parishes had access to radiology services within 20 and 30 miles, respectively. Not all members in urban and rural parishes had access to lab services within 20 and 30 miles, respectively. Lab services are a challenge that the MCO addresses through negotiating for additional access points through Quest and LabCorp. Some providers and national and do not reflect as providers on their GeoAccess reports even though they are providing services to members in LA. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .3 Travel distance shall not exceed 10 miles in urban parishes; and .4 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on page 14. Not all members in urban parishes (97%) had access to pharmacies within 10 miles. All members in rural parishes had access to pharmacies within 30 miles. **Recommendation**	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					The MCO should continue to enroll providers to ensure it meets the access requirements.	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .3 Travel distance shall not exceed 10 miles in urban areas; and .4 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the NPDMP on page 15. Not all members in urban and rural parishes had access to hemodialysis centers within 10 and 30 miles, respectively. About one-fifth of urban members and more than one-third of rural members did not have access to hemodialysis centers within these parameters. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the NPDMP on page 46. Over 90% of members in rural parishes had access to BH specialists and psychiatrists within 30 miles or 60 minutes.	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the NPDMP on page 46. Over 90% of members in urban parishes had access to BH specialists and psychiatrists within 15 miles or 30 minutes.	
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for	Network Provider Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 46;	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Policy for Access and Availability GeoAccess reports Requests for exceptions			Over 90% of members in urban and rural parishes had access to psychiatric inpatient hospital services within 90 miles or 90 minutes.	
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission/appointment maximum time is addressed in the Access to Care Plan on page 8. None of the members in urban or rural parishes had access to ASAM Level 3.3 services within 30 miles or 90 minutes. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8. Fewer than 60% of adult and adolescent members had access to ASAM Level 3.5 services within the indicated parameters. Only 13.9% of adolescent members had access to ASAM Level 3.5 services within 60 miles or 90 minutes. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring	Network Provider		Minimal	The distance and time requirements are	MCO continues

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions			addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8. Fewer than 30% of members in urban and rural parishes had access to ASAM Level 3.7 services within 60 miles or 90 minutes. For urban parishes the access rate was 16.8% and for rural parishes it was 27.1%. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Minimal	The distance and time requirements are addressed in the NPDMP on page 46. The admission and appointment maximum time is addressed in the Access to Care Plan on page 8, except for withdrawal management (24-hour) requirement. Fewer than 90% of adult members in urban and rural parishes had access to ASAM Level 3.7WM services. For urban parishes the access rate was 16.8% and for rural parishes it was 27.1%. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	MCO continues outreaching to providers for enrollment efforts in key areas and for provider types needed to meet all member needs and access requirements.
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20	Network Provider Development and Management Plan Policy for Access and		Substantial	The distance and time requirements are addressed in the NPDMP on pages 19 and 46. The admission and appointment maximum time is not addressed in any	MCO continues outreaching to providers for enrollment efforts in key areas and for provider

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Availability GeoAccess reports Requests for exceptions			policy. Not all members had access to PRTFs within 200 miles or 3.5 hours. **Recommendation** The MCO should continue to enroll providers to ensure it meets the access requirements.	types needed to meet all member needs and access requirements. We have been working with an organization that has 3 locations in the state in hopes of contracting with them. We will continue our efforts with them! We are also in discussions with an out of state facility for potential contracting, if the need arises. They are in a contiguous state.
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the NPDMP on page 28.	
7.3.7.10	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	Policy for Access standards Member handbook		Full	This requirement is addressed in the NPDMP on page 19.	
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 the Provider Network Companion Guide.	Network Provider Development and Management Plan Policy for Access and Availability Evidence of meeting provider to member ratios		Full	This requirement is addressed in the NPDMP on page 4. The PH Access Adequacy and GeoAccess Review Report dated April 15, 2019 for the period of July 31, 2018 to January 31, 2019 evidences the implementation of	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					this requirement. The ratios tab uses the ratios indicated in the Provider Network Companion Guide. The MCO's ratios exceed the required ratios for every type of provider and specialist.	
7.5	**Monitoring and Reporting on Provider Networks**					
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Network Provider Development and Management Plan Provider contracts Provider manual/handbook Policy for Access and Availability Policy for Monitoring Provider Compliance with Access Standards Plan website Evidence that monitoring was implemented		Full	This requirement is addressed in the Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan on page 6 and in the provider manual on pages 22 to 24. After-hours coverage is addressed in the provider manual on pages 24 and 25 under "Telephone Accessibility Standards" and monitoring appointment availability is addressed in the Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan on page 6. The 2018 Provider Access Appointment Availability and After-Hours Audits Report evidences the implementation of this requirement.	
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed the Provider Network Companion Guide. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider	GeoAccess reports Communication to LDH/ attestation		Full	This requirement is addressed in the NPDMP on pages 29 and 38. The GeoAccess reports evidence the implementation of this requirement. The NPDMP addresses identified gaps in access. The network adequacy reports include signed attestations;	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	registry data submitted to LDH by the plans as required in the **MCO Systems Companion Guide.** The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.					
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** • Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.	GeoAccess reports Communications to LDH		Full	This requirement is addressed in the NPDMP on pages 4 and 29. The GeoAccess reports evidence the implementation of the requirement for ratio reporting and analysis.	
7.6		**Provider Enrollment**				
7.6.1	**Provider Participation -**					
7.6.1.6	The MCO must offer a Contract to the following providers: • Louisiana Office of Public Health (OPH); • all OPH-certified School Based Health Clinics (SBHCs); • all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs); • Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the NPDMP on pages 8 and 21.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).		-			
7.6.1.7	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.	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the NPDMP on page 11.	
7.6.1.8	If a current Medicaid provider requests participation in an MCO, the MCO shall make a	Network Provider Development and		Full	This requirement is addressed in the NPDMP on pages 8 and 9.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	Management Plan Policy for Provider Network				
7.6.1.9	The provisions above do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do 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)].	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the NPDMP on page 9.	
7.6.1.10	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)].	Network Provider Development and Management Plan Policy for Provider Network Policy for Provider Selection and Retention Evidence of timely notice of denied provider requests for participation Sample notice to providers		Full	This requirement is addressed in the NPDMP on page 10.	
7.6.1.11	The MCO shall work with LDH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Policy for care coordination Meeting/Forum Meetings		Full	This requirement is addressed in the Coordination of Member Care Policy on pages 1 and 4. The MCO provided meeting planners showing participation in MCO workgroups.	
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Network Provider Development and Management Plan Policy for Provider Network Policy for Provider Credentialing Policy for Provider Selection and Retention		Full	This requirement is addressed in the NPDMP on page 9. The Provider Network Voluntary and Involuntary Terminations Policy also addressed this requirement. The RCA Medicaid Provider Contract evidences the implementation of this requirement.	
7.6.2.2 7.6.2.2.1 7.6.2.2.2 7.6.2.2.3 7.6.2.2.4 7.6.2.2.5 7.6.2.2.6	The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c-5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings: .1 Revocation of the provider's home and community-based services license or behavioral health service license; .2 Exclusion from the Medicaid program; .3 Termination from the Medicaid program; .4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41); .5 Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC	Policy for Provider Network		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.					
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	Policy for Provider Network		Substantial	This requirement is not addressed in any of the policies submitted for review. However, the RCA contract evidences the implementation of this requirement on page 4. **Recommendation** The MCO should include this requirement in its policies regarding provider network.	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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)] The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(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)].	Network Provider Development and Management Plan Policy for Provider Network Policy for Provider Selection and Retention Policy for Provider Credentialing		Full	This requirement is addressed in the NPDMP on page 9.	
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.	Network Provider Development and Management Plan Policy for Provider Network Provider manual/handbook Policy for Provider Credentialing		Full	This requirement is addressed in the NPDMP on page 10 and in the provider manual on page 37.	
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day	Policy for Provider Network Policy for Provider Termination Sample notice to providers		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	Sample notice to LDH			6.	
7.6.3.5	If termination affects network adequacy, the MCO shall include in the notification to LDH their plans to notify MCO members of such change and strategy to ensure timely access for MCO members through different in-network and/or 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 there will be no stoppage or interruption of services to members.	Policy for Provider Network Policy for Provider Termination Sample notice to members		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 9.	
7.6.3.6	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 care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	Policy for Provider Network Policy for Provider Termination Sample notice to members Member Handbook		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on pages 6 and 9. See above	
7.7	**Mainstreaming**					
7.7.1	LDH 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.	Provider contracts Provider Handbook/Manual		Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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	Provider contracts Provider Handbook/Manual Member Handbook		Substantial	This requirement is partially addressed in the NPDMP on page 73; however, the specifics of this requirement, for example income status and cognitive disability, are	We accept this recommendation and will update our Network policies accordingly, as we

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:				not included in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	already comply in practice.
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts Provider Handbook/Manual		Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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.	Provider contracts Provider Handbook/Manual		Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
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.	Provider contracts Provider Handbook/Manual		Substantial	This requirement is not addressed in any policy. The RCA contract evidences the implementation of this requirement on page 16. **Recommendation** The MCO should include this requirement in its policies regarding provider network	We accept this recommendation and will update our Network policies accordingly, as we already comply in practice.
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the	Policy for provider contracts Provider Contract Provider Handbook		Full	This requirement is partially addressed in the Provider Monitoring and Reporting Policy on pages 3 and 4.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	behavioral health provider within thirty (30) calendar days and notify LDH in writing					
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Policy for provider contracts Provider Contract Provider Handbook		Full	This requirement is addressed in the NPDMP on page 85.	
7.8.2	**Primary Care Provider Responsibilities**					
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:					
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on pages 28 and 29. The RCA contract evidences the implementation of this requirement on page 5.	
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;	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on pages 28 and 29. The RCA contract evidences the implementation of this requirement on page 5.	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	Policy for PCP responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on pages 28 and 29. The RCA contract evidences the implementation of this requirement on page 5.	
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;	Policy for PCP responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on pages 28 and 29. The RCA contract evidences the implementation of this requirement on page 5.	
7.8.2.5	Maintaining a medical record of all services	Policy for PCP Responsibilities		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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;	Provider Handbook/Manual Provider contracts			provider manual on pages 28 and 29. The RCA contract evidences the implementation of this requirement on page 5.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on pages 49. The RCA contract evidences the implementation of this requirement on page 5.	
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.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 56 and in the member handbook on pages 15 and 16. The RCA contract evidences the implementation of this requirement on page 5.	
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.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 24. The RCA contract evidences the implementation of this requirement on page 5.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 29. The RCA contract evidences the implementation of this requirement on page 5.	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 53. The RCA contract evidences the implementation of this requirement on page 6.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 53 under "Coordination Between Behavioral Health and Physical Health Services." The RCA contract evidences the implementation of this requirement on page 6.	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 53. The RCA contract evidences the implementation of this requirement on page 6.	
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.					
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	Policy for Provider Network Policy for Access to Specialty Providers GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 21 and evidenced by the GeoAccess reports.	
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.	Policy for Provider Network Policy for Access to Specialty Providers GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 21 and evidenced by the GeoAccess reports and in the RCA contract on pages 6 and 8.	
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	Policy for Provider Network Policy for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider		Substantial	This requirement is addressed in the NPDMP on page 21 and evidenced by the GeoAccess reports. **<u>Recommendation</u>** The MCO should continue to enroll	The MCO will continue outreaching to providers in an effort of enrollment and contracting in multiple areas and with various provider types and

Provider Network Requirements						
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	means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	types			providers to ensure it meets the access requirements.	specialties to meet our members needs.
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements set in this Section and in the Provider Network Companion Guide.					
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 LDH the MCO does not meet the access standards specified in the Contract.	Policy for Provider Network Policy for Access to Specialty Providers		Full	This requirement is addressed in the NPDMP on page 21.	
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.	Policy for Provider Network Policy for Access to Specialty Providers Policy for direct access services		Full	This requirement is addressed in the NPDMP on page 21.	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.					
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: .1 One (1) hospital that provides emergency	Policy for Provider Network GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 23, which also states that the MCO "holds contracts with most	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. .2 MCO must establish access to the following within their network of hospitals: • Level III Obstetrical services; • Level III Neonatal Intensive Care (NICU) services; • Pediatric services; • Trauma services; • Burn services; and • A Children's Hospital that meets the CMS definition in 42 CFR, Parts 412 and 413.				hospitals in the state including all critical access hospital and health systems." This requirement is also addressed in the Access to Care Plan on page 5	
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	Policy for Provider Network GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 27, which states that the MCO is building its network including out-of-state providers and hospital systems, and on page 32	
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.	Policy for Provider Network GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 32. The GeoAccess reports evidence the implementation of this requirement.	
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	Policy for use of out-of-network providers Policy for providing access to tertiary care GeoAccess reports		Full	This requirement is addressed in the NPDMP on page 32.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	arrangements with out-of-network providers.					
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.	Policy for direct access services		Full	This requirement is addressed in the NPDMP on page 9, in the member handbook on page 30, and in the provider manual on page 43.	
7.8.6.1	The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.	Policy for direct access services		Full	This requirement is addressed in the NPDMP on pages 9 and 31 and in the Family Planning/Reproductive Health Policy on page 4. The GeoAccess reports show that the MCO's network includes providers who can offer family planning services.	
7.8.6.2	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.	Policy for direct access services Member Handbook		Full	This requirement is addressed in the member handbook on page 34 and in the Family Planning/Reproductive Health Policy on page 3.	
7.8.6.3	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	Policy for direct access services Member Handbook		Full	This requirement is addressed in the member handbook on page 34 and in the Family Planning/Reproductive Health Policy on pages 4 and 6.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.					
7.8.6.5	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	Policy for Direct Access Services		Full	This requirement is addressed in the Family Planning/Reproductive Health Policy on page 6.	
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.	Policy for Prenatal Care Services Access Policy for Assignment of PCPs including Auto Assignment		Full	This requirement is addressed in the member handbook on pages 35 and 36 and in the Prenatal Services Policy on page 1.	
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.	Evidence of availability of other medical service providers		Full	This requirement is addressed in the NPDMP on page 23. The network adequacy reports evidence the availability and monitoring of the services included in this requirement.	
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)	Policy for Provider Network Contracts with FQHC/RHCs		Full	This requirement is addressed in the NPDMP on page 23.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	in the state.					
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the LDH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.					
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	Policy for Provider Network Contracts with SBHCs		Full	This requirement is addressed in the NPDMP on page 23.	
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, STI, family planning).	Policy for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the NPDMP on page 23.	
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.	Policy for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the NPDMP on page 23.	
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 40. The GeoAccess and network adequacy reports evidence the availability and monitoring of access to specialized BH providers.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8.14.2	The MCO shall ensure its provider network offers a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. The provider network shall be adequate for the anticipated number of members for the service area. The service array shall comply with the waivers and Medicaid State Plan requirements.					
7.8.14.3	The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.			Full	This requirement is addressed in the NPDMP on page 40	
7.8.14.4	The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.			Full	This requirement is addressed in the NPDMP on pages 8 and 37.	
7.8.14.5	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page19.	
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC	Policy for provider network Policy for care coordination		Full	This requirement is addressed in the NPDMP on page19.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	Network reports				
7.8.14.7	The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on pages 29 and 37 and in the Assessment of Network: Adequacy, Availability and Access to Care Monitoring Plan on page 6. The 2018 Provider Access Appointment Availability and After-Hours Audits Report evidences the ongoing monitoring of after-hours availability of providers, including BH providers.	
7.8.14.8	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, warm line, crisis counseling crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, mobile crisis teams, and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. If shortages in provider network sufficiency are identified by LDH, the MCO shall conduct outreach efforts approved by LDH, and take	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on pages 42 and 43.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.					
7.8.14.10	The MCO shall require behavioral health providers to screen for basic medical issues.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 43 and in the provider manual on page 53.	
7.8.14.11	The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 32.	
7.8.14.12	The MCO shall report the number of out-of-state placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	Policy for provider network Policy for care coordination		Substantial	This requirement is not included in any policy provided by the MCO. The monthly behavioral health out-of-state reports evidence the implementation of this requirement. **<u>Recommendation</u>** The MCO should include this language in their policies and procedures.	We accept this recommendation and will ensure our policies are updated appropriately.
7.8.15 7.8.15.1	**Indian Health Care providers (IHCPs)** The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 75.	
7.8.15.2 7.8.15.2.1	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8.15.2.2 7.8.15.2.3	provided to Indian members who are eligible to receive services from such providers as follows: • At a rate negotiated between the MCO and the IHCP; or • In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and • Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.			Full	This requirement is addressed in the NPDMP on page 75.	
7.8.15.4	The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.			Full	This requirement is addressed in the NPDMP on page 75.	
7.8.15.5 7.8.15.5.1 7.8.15.5.2	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .1 Indian members are permitted by the MCO to access out-of-state IHCPs; or .2 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 75.	
7.8.15.6	The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the NPDMP on page 75.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
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 LDH 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 438.68):	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 1 and 9.	
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 2.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 2.	
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;	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 4 to 7.	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 20.	
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.	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 3 and 4.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Provider Network Development and Management Plan		Full	This requirement is evidenced by the NPDMP.	
7.9.2.1	Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 3 and 4.	
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members in the service area;	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 2 and 25.	
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 5, 12 and 13.	
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 5 to 7 and on page 15.	
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 5 and 15.	
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 2, 11, 18 and 19.	
7.9.2.7	Timely Access	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 12 to 19.	
7.9.2.8	Service Area	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 12 to 19, 21 and 23.	
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health , • Special Conditions for Prenatal Providers,	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 9.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• Second Opinion • Out-of-Network Providers					
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. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on pages 20 and 25 to 27.	
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 40.	
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory		Full	This requirement is addressed in the NPDMP under the topic of specialized behavioral health providers. The MCO provider look up allows selecting multiple specialties.	
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 LDH quarterly, or upon material change (as defined in the Glossary) or upon request.	Provider Network Development and Management Plan GeoAccess reports		Full	This requirement is addressed in the NPDMP on pages 28 and 29 and evidenced by the GeoAccess and network adequacy reports.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 25, 29 and 30.	
7.9.5.2	Monitor network compliance with policies and rules of LDH 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;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 29 to 31.	
7.9.5.3	Evaluate the quality of services delivered by the network;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 31 and 32.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on page 32 and in the Practitioner and Provider Availability: Network Composition and Contracting Plan on page 8.	
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	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 32 and 93 and in the Practitioner and Provider Availability: Network Composition and Contracting Plan.	
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;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 26, 29 and 30.	
7.9.5.7	Provide training for its providers and maintain records of such training;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on pages 31 and 32 and in the Provider Relations Department Functions and Responsibilities Policy;	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Policy for Network Development and Management		Full	This requirement is addressed in the NPDMP on page 34 and in the Provider Complaints Policy on pages 4 and 6.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Policy for Network Development and Management		Full	This requirement is addressed in the Provider Complaints Policy on page 6.	
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 LDH at the end of the first year of operations and annually thereafter.	Policy for Evaluation of Network Provider Development and Management Plan		Full	This requirement is addressed in the NPDMP on page 9.	
7.9.7	MCO Network Development and Management policies shall be subject to approval by LDH, Medicaid Managed Care Section and shall be monitored through operational audits.	Evidence of submission of policy for Network Development and Management to LDH		Full	This requirement is addressed in the NPDMP on page 30.	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to LDH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the NPDMP on page 40. The NPDMP includes the required section starting on page 40.	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the NPDMP.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following	Network development Implementation plan		Full	This requirement is addressed in the NPDMP on page 44.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Policy for provider network				
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the NPDMP on pages 44 and 45.	
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to LDH quarterly by contract year, upon material change of the network, or upon request;	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the NPDMP on pages 46, 47 and pages 49 to 59.	

	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:
	  • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
	  • Specialized behavioral health service needs of members; and
	  • Growth trends in eligibility and enrollment, including:
	  o Current and anticipated numbers of Title XIX and Title XXI eligibles; and
	  o Current and desired specialized
		Policy for network
		Needs assessment findings
				Full	This requirement is met in the NPDMP on pages 48, 49, 59 and 60.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.					
	• Accessibility of services, including: o The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; o The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; o Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the NPDMP on pages 18 and 19.	
7.9.8.3	The MCO shall submit to LDH as part of its annual Network Development and Management Plan, and upon request of LDH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and	Evidence of submission of network development Plan to LDH Network and development plan		Full	This requirement is addressed in the NPDMP on pages 44, 45, 48, 49, 60 to 62.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.					
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and	Network development and management plan		Full	This requirement is addressed in the NPDMP on pages 62 to 68.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.					
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: • Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.	Network development and management plan		Full	This requirement is addressed in the NPDMP on pages 64 to 66 and 83 to 85.	
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy,	Network development and management plan		Full	This requirement is addressed in the NPDMP on pages 72 to 83. The NPDMP states that, "The Provider Relations On-site Visit Form assesses and collects information related to cultural competency areas such ADA Accessible, furniture, equipment, and environmental accommodations for individuals living with disabilities. The form also assesses if educational materials in the office are in Spanish and other languages."	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of	Network development and management plan		Full	This requirement is addressed in the NPDMP on page 9 and pages 94 to 96.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	specialized behavioral healthcare.					
7.11	**Material Change to Provider Network**					
7.11.1	The MCO shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.	Evidence of communications with LDH Policy for provider contracting		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 7.	
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in value-added benefits and services, payments, or	Evidence of communication with LDH Policy for Provider network		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 7.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	eligibility of a new population.					
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Request for approval communications Notification to Member		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 8.	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Request for approval		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 8.	
7.11.5	If LDH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, LDH will expedite the approval process.					
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	Notification to LDH Policy for provider network		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 8.	
7.11.7	MCO's shall give hospitals and provider groups	Provider contracts		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Policy for provider contracting			Provider Network Voluntary and Involuntary Terminations Policy on page 8.	
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: .1 Provide written notice to LDH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH.	Evidence of notifications Policy for provider network		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 7.	
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	Policy for provider network		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 3.	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the	Request for approval letter		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 8;	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	expected implementation of the change. .1 The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.					
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to LDH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.	Written plan Policy for provider network		Full	This requirement is addressed policy LA 6100.90.	
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth,	Tracking report Policy for service coordination		Minimal	The MCO provided the network development plan in support of this requirement, however the required language was not found. The MCO states that no suspensions or	We accept this recommendation and will ensure our policies are updated appropriately.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).				terminations occurred during the review period that would trigger the reporting requirements contained in this element. **Recommendation** The MCO should include the required language in their policies and procedures.	
7.12	**Coordination with Other Service Providers**					
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Policy for Coordination with Other Service Providers		Full	This requirement is addressed in the Coordination of Member Care Policy on pages 4 and 6.	
7.13	**Provider Subcontract Requirements**					
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Policy for Network Management Policy for Provider Selection and Retention		Full	This requirement is addressed in the NPDMP on page 9. This requirement is also addressed in the Practitioner Credentialing, Recredentialing Policy on page 1.	
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**					
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO	Policy for credentialing & recredentialing		Substantial	This requirement is addressed in the Credentialing Policy and Procedure Development Amendment on page 1; however, the timeliness requirement is not included in this policy. The requirement is also addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period on May 2019. As such,	We accept this recommendation and will ensure the policy is updated appropriately.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.				the timeliness requirement is not included in any policy submitted for review. **Recommendation** The MCO should include the timeliness requirement in their policies.	
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA);	Policy for provider contracting		Substantial	This requirement is addressed in the Non-Traditional Provider Credentialing Policy on pages 2 and 3; however, this language was added after the review period on May 2019. **Recommendation** The MCO should finalize the Non-Traditional Provider Credentialing Policy to include this requirement for review in the next cycle.	We accept this recommendation and will ensure the policy is finalized with the appropriate language.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).					
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	Policy for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the Practitioner Application Policy on page 2. File review verified the MCO follows credentialing standards, such as verification of current licenses, work history, malpractice coverage, and professional liability claims history, education or board certification verification, DEA/CDS certifications, exclusion lists, state, federal, Medicare, and Medicaid sanctions including those published or maintained by OIG, AMA, or NPDB. For re-credentialing files, the files were verified for timeliness of re-credentialing, board-certifications if applicable, current licenses, valid DEA/CDS certifications if any, and the attestation. **Credentialing File Review Results** Five (5) of five (5) files met the standards for credentialing verification. **Recredentialing File Review Results** Five (5) of five (5) files met the standards for recredentialing verification.	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Application Policy on page 2.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Application Policy on page 2.	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	Policy for credentialing & recredentialing Policy for subcontractor delegation and requirements Credentialing subcontractor contract Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the Practitioner Application Policy on page 2. The policy indicates that credentialing will be processed completely in 30 days. **Credentialing File Review Results** Five (5) of five (5) files met the standards for credentialing verification.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Application Policy on page 2.	
7.14.5.2	Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or	Policy for credentialing & recredentialing Provider Directory Evidence of submission of the Provider Directory		Full	This requirement is addressed in the Practitioner Application Policy on page 2.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Application Policy on page 2.	
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.	Policy for credentialing & recredentialing Delegation Contracts		Full	This requirement is addressed in the Delegation Oversight Responsibilities Policy on page 1.	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	Policy for credentialing & recredentialing		Substantial	This requirement is not addressed in any of the policies submitted for review. The RCA contract evidences the implementation of this requirement on	We accept this recommendation and will update our policies accordingly.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					page 19. **Recommendation** The MCO should include this requirement regarding credentialing of specialized BH providers in its credentialing and recredentialing policies.	
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing Policy and Procedure Development Amendment on page 2.	
7.14.9	The MCO shall notify LDH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	Policy for credentialing & recredentialing		Substantial	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period in May 2019. The RCA contract states that the subcontractor will notify MCO, not LDH, on page 19. **Recommendation** The MCO should finalize the Practitioner Credentialing, Recredentialing Policy to include this requirement for review in the next cycle.	We will ensure the policies are updated appropriately.
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	Policy for credentialing & recredentialing		Substantial	This requirement is addressed in the Practitioner Credentialing, Recredentialing Policy on page 1; however, this language was added after the review period in May 2019.	We will ensure the policy is finalized with the updated language.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					The RCA contract evidences the implementation of this requirement on page 19. **Recredentialing File Review Results** Five (5) of five (5) files were completed for recredentialing within three years. **Recommendation** The MCO should finalize the Practitioner Credentialing, Recredentialing Policy for review in the next cycle.	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	Policy for credentialing & recredentialing		Substantial	This requirement is not addressed in any of the policies submitted for review. The MCO does have policies and procedures for approval of providers, and termination or suspension of providers that evidence the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	We will update our policies to ensure the requirement language is added in accordance with our practice of the requirement.
7.14.12	The MCO shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	Policy for credentialing & recredentialing Policy for reporting provider quality deficiencies Documented process for reporting quality deficiencies resulting in suspension or termination		Full	This requirement is addressed in the Reporting Sanctions: NPDB and State Licensing Authorities Policy on page 2.	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for	Policy for credentialing & recredentialing Policy for provider dispute and appeal process Documented provider dispute and resolution process for		Substantial	This requirement is not addressed in any of the policies submitted for review. However, the MCO does have policies and processes for provider dispute (Provider Dispute Resolution Policy), provider complaints (Provider Complaints Policy),	We will update our policies to ensure the requirement language is added in accordance with our practice of the requirement.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	sanctions, suspensions and terminations Evidence of timely process submission			provider appeals (Provider Appeals Policy), and sanctions and terminations (Provider Network Voluntary and Involuntary Terminations Policy) that evidence the implementation of this requirement. During onsite interviews, The MCO described how provider grievances go through their regular queue process. Non claims disputes such as quality of care issues go out to the relevant team. There are different entry points for issues based on type ie grievance v compliance. Etc **Recommendation** The MCO should include this requirement in its policies.	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.					
7.16	**Provider-Member Communication Anti-Gag Clause**					
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 28. The RCA contract evidences the implementation of this requirement on page 7.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	under the Contract, for the following:					
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 28. The RCA contract evidences the implementation of this requirement on page 7.	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 28. The RCA contract evidences the implementation of this requirement on page 7.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 28. The RCA contract evidences the implementation of this requirement on page 7.	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 28. The RCA contract evidences the implementation of this requirement on page 7.	
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.					
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Policy for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts Member Handbook		Substantial	This requirement is not addressed in any of the policies submitted for review. The RCA contract partially evidences the implementation of this requirement on page 7; however, does not explicitly indicate "information disclosure requirements related to physician incentive plans." **Recommendation** The MCO should include this requirement in its policies.	We accept the recommendation and will update our policies accordingly.

Utilization Management

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.1	**General Requirements**					
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to LDH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	Policy for UM Evidence of timely submission of Policy for UM		Substantial	This requirement is partially addressed in the Prior Authorization Policy, page 12 and the Concurrent Review/OBS Care Policy, pages 6-7. The MCO states that policies for 2019 were reviewed and submitted to LDH on 6/2/19. There was no evidence of transmission provided, and furthermore, there was no evidence that policies from 2018 (9/12 months of the review period) were submitted to LDH. During the interview on-site, the MCO stated that despite having updated their policy, they did not recall sending the updated policy to LDH. **Recommendation** The MCO should ensure that UM policies and procedures are submitted to LDH for timely approval.	Aetna Better Health of Louisiana will submit policies and procedures to the state as required no later than 30 days from final approval.
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:					
8.1.2.1	Are adopted in consultation with contracting health care professionals;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy on page 12 and the Concurrent Review/OBS Care Policy, page 7.	
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12 and the Concurrent Review/OBS Care Policy, page 7.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.1.2.3	Are considerate of the needs of the members; and	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12 and the Concurrent Review/OBS Care Policy, page 7.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12 and the Concurrent Review/OBS Care Policy, page 7.	
8.1.3	The policies and procedures shall include, but not be limited to:					
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 12.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 13 and the Concurrent Review/OBS Care Policy, page 7.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	Policy for UM Policy for Coordination of services		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	Policy for UM Policy for Coordination of services		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	Policy for UM Policy for Coordination of services		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	Policy for UM Policy for Coordination of services		Full	This requirement is addressed in the Prior Authorization Policy, page 13.	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	Policy for UM Policy for Coordination of services		Full	This requirement is addressed in the Prior Authorization Policy, page 13; and the Transition Coordination log provided.	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Policy for UM Policy for guideline development coordination Policy for guideline research, selection, adoption, review, update, & update schedule Sample adopted guidelines		Full	This requirement is addressed in the Process for Approving and Applying Medical Necessity Criteria Policy as well as a document that was provided on-site demonstrating tracking and comparing MCO guidelines.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Policy for UM Policy for guideline dissemination Sample adopted guidelines		Full	This requirement is addressed in the Process for Approving and Applying Medical Necessity Criteria Policy, page 6 and the 2019 UM Program Description, page 18.	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial	Provider contracts Compliance reports		Full	This requirement is addressed in the Process for Approving and Applying Medical Necessity Criteria Policy on page 5. The MCO did not provide provider contracts or compliance reports as supporting documentation for this requirement.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	incentives, to improve compliance.					
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Prior Authorization Policy, page 27 and the CCR-OBS Care Policy, pages 23-24.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Prior Authorization Policy, page 27 and the CCR-OBS Care Policy, pages 23-24.	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Prior Authorization Policy, page 27 and the CCR-OBS Care Policy, pages 23-24.	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Prior Authorization Policy, page 27 and the CCR-OBS Care Policy, pages 23-24.	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	Policy for UM Policy for medical management criteria		Full	This requirement is addressed in the Prior Authorization Policy, page 27 and the CCR-OBS Care Policy, pages 23-24.	
8.1.7	UM Program medical management criteria and practice guidelines shall be posted to the MCO's website. If the MCO uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, the MCO may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the MCO must provide the specific criteria and practice guidelines utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Policy for UM Policy for guideline dissemination		Full	This requirement is addressed in the Prior Authorization Policy, page 26; the CCR-OBS Care Policy, page 24; and the webpage link to the Clinical Policy Bulletins on the MCO's website.	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when	Policy for UM Policy for required information Policy for additional information		Full	This requirement is addressed in the CCR-OBS Care Policy, page 21.	

Utilization Management						
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	requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.					
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 26 and the CCR-OBS Care Policy, page 21.	
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: • Specialized behavioral health services, and • PSH to ensure appropriate authorization of tenancy services.	Policy for UM Staffing plan		Full	This requirement is addressed in the Prior Authorization Policy, pages 23-24; and the CCR-OBS Care Policy, page 9.	
8.1.11	The MCO shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 26 and UM Program Description, page 14.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	Policy for UM Staffing plan		Full	This requirement is addressed in the Prior Authorization Policy, page 14.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, pages 14-15 and the Clinical Personnel License Requirements Policy, page 2.	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	Policy for UM Includes UM File Review		Full	This requirement is addressed in the Clinical Personnel License Requirements Policy, page 2 and the Prior Authorization Policy, page 24. **<u>File review results</u>** Ten (10) out of 10 Utilization Management files reviewed were reviewed by a licensed clinical	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					professional.	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 24.	
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 24.	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 24.	
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 25.	
8.4	**Service Authorization**					
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post	Policy for UM Policy for service		Full	This requirement is addressed in the Prior Authorization Policy, page 22 and	

Utilization Management						
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	authorization.	authorization			the CCR-OBS Care Policy, page 7.	
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Gee and Wells v. Gee* for initial and continuing authorization of services that include, but are not limited to, the following:	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 22 and the CCR-OBS Care Policy, page 7.	
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 22 and the CCR-OBS Care Policy, page 7.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 22 and the CCR-OBS Care Policy, page 7.	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 23 and the CCR-OBS Care Policy, page 8.	
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 23; the CCR-OBS Care Policy, page 8; and the member handbook on page 11.	
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 23 and the CCR-OBS Care Policy, page 8.	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 23; the CCR-OBS Care Policy, page 8; and the service authorization reports	

Utilization Management						
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	data to support the decision, and time frames for notification of providers and members of decisions.				provided for 1/19-3/19.	
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	Policy for UM Policy for service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 25 and the CCR-OBS Care Policy, page 12.	
8.4.4	Not later than July 1, 2018, the MCO shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.	Policy for prior authorization Policy for UM		Full	This requirement is addressed in the Common Hospital Observation Policy draft, page 1; and the CCR-OBS Care Policy, page 15.	
8.4.5	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals.	Policy for prior authorization Policy for UM		Full	This requirement is addressed in the CCR-OBS Care Policy, page 16.	
8.4.5.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	Policy for UM		Full	This requirement is addressed in the CCR-OBS Care Policy, page 16.	
8.4.5.2	Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	Policy for UM		Full	This requirement is addressed in the CCR-OBS Care Policy, page 16.	
8.4.5.3	Concurrent utilization review includes:	Policy for UM		Full	This requirement is addressed in the	

Utilization Management						
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	Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the	Evidence of timely submissions Notification communication to member/provider			CCR-OBS Care Policy, pages 17-19.	

Utilization Management						
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	referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.					
8.4.6	Certification of Need (CON) for PRTFs					
8.4.6.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.					
8.4.6.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to-face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	Policy for Service utilization Policy for Certification/recertification		Full	This requirement is addressed in the Prior Authorization Policy, page 38 and the prior authorization and concurrent review for PRTF desktop provided by the MCO.	
8.4.6.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a	Policy for UM LMHP Subcontract		Full	This requirement is addressed in the Prior Authorization Policy, page 38 and the prior authorization and concurrent review for PRTF desktop provided by the MCO.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).					
8.4.6.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	Policy for certification		Full	This requirement is addressed in the Prior Authorization Policy, page 38 and the prior authorization and concurrent review for PRTF desktop provided by the MCO.	
8.4.6.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. • Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility. o Upon completion of the screen, if the PRTF is approved, within 48 hours the MCO shall notify in writing the provider requesting the certification of the results, the member/guardian and, with member guardian consent, the referring party requesting the PRTF services on behalf of the youth. If approved, the MCO shall, in consultation with the member's guardian and referring party, locate a PRTF provider appropriate to meet the member's needs with availability to admit the member. o If denied, the MCO shall notify the provider requesting the certification immediately and within 48 hours provide written notification to the provider requesting the certification of the results, the member/guardian and, with the member/guardian consent, the referring party requesting the PRTF services on behalf of the youth. The notification shall include: information on alternative community services that may meet the member's needs to ensure health and safety, including information on	Policy for certification Tracking report Policy for UM Hospital reports		Full	This requirement is addressed in the Prior Authorization Policy, pages 38-39 and the prior authorization and concurrent review for PRTF desktop provided by the MCO.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	available providers of those services, the right of the member to appeal, and the process to do so. For youth pending release from a secure setting for whom a PRTF is being requested, the MCO is required to coordinate the completion of the screen and the CON prior to the youth's release if it is anticipated that the youth will be re-linked to the MCO following release. o Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. o Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. o Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. o Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.					
8.5	**Timing of Service Authorization Decisions**					
8.5.1	**Standard Service Authorization**					
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	Policy for UM Policy for standard service authorization		Full	This requirement is addressed in the Prior Authorization Policy.	
8.5.1.1.1 8.5.1.1.1.1	The service authorization decision may be extended up to fourteen (14) additional calendar days if:			Full	This requirement is addressed in the Prior Authorization Policy, page 33.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.5.1.1.1.2	• The member, or the provider, requests the extension; or • The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.					
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	Policy for UM Policy for concurrent review determinations		Full	This requirement is addressed in the CCR-OBS Care Policy, page 15.	
8.5.2	**Expedited Service Authorization**					
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	Policy for UM Policy for expedited service authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 29.	
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to LDH a need for additional information and how the extension is in the member's best interest.	Policy for UM Policy for post authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 29.	
8.5.3	**Post Authorization**					
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Policy for UM Policy for post authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 37.	
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was	Policy for UM Policy for post authorization		Full	This requirement is addressed in the Prior Authorization Policy, page 37 and the CCR-OBS Care Policy, page 9.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	based upon a material omission or misrepresentation about the member's health condition made by the provider.					
8.5.4	**Timing of Notice**					
8.5.4.1	**Notice of Action**					
8.5.4.1.1	**Approval [Notice of Action]**					
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Policy for UM Policy for notice timing Includes UM File Review		Full	This requirement is addressed in the Prior Authorization Policy, page 28. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed met the notification of decision requirements.	
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	Policy for UM Policy for notice timing		Full	This requirement is addressed in the Prior Authorization Policy, page 29 and the CCR-OBS Policy, page 25.	
8.5..4.1.2	**Adverse [Notice of Action]**					
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	Policy for UM Policy for notice timing Includes UM File Review		Full	This requirement is addressed in the Prior Authorization Policy, pages 29-30. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed showed evidence of notification to the member in writing using language that was easily understood by the member.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision	Policy for UM		Full	This requirement is addressed in the	

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	to deny an authorization request or reauthorization or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.	Policy for notice timing Includes UM File Review			Prior Authorization Policy, page 30. **File Review Results** Ten (10) out of 10 Utilization Management files reviewed met the notification of decision requirements.	
8.5.4.1.3	**Informal Reconsideration**					
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Policy for UM Policy for informal reconsideration		Full	This requirement is addressed in the Prior Authorization Policy, page 20 and the CCR-OBS Care Policy, page 14. **File Review Results** Five (5) out of 5 Informal Reconsideration files reviewed met the requirement of allowing a member reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	Policy for UM Policy for informal reconsideration		Full	This requirement is addressed in the Prior Authorization Policy, page 20 and the CCR-OBS Care Policy, page 14.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working	Policy for UM Policy for informal reconsideration Policy for notice timing Includes Informal Consideration File Review		Full	This requirement is addressed in the Prior Authorization Policy, page 20 and the CCR-OBS Care Policy, page 14. **File Review Results** Five (5) out of 5 informal reconsideration files reviewed met the	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	day.				one (1) day requirement.	
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	Policy for UM Policy for informal reconsideration Policy for notice timing		Full	This requirement is addressed in the Prior Authorization Policy, page 20 and the CCR-OBS Care Policy, page 14.	
8.5.4.2	**Exceptions to Requirements**					
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10 and the CCR-OBS Care Policy, page 15.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10 and the CCR-OBS Care Policy, pages 15-16.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10 and the CCR-OBS Care Policy, pages 15-16.	
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10 and the CCR-OBS Care Policy, pages 15-16.	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10.	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10.	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 10.	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 11.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 11 and the CCR-OBS Care Policy, page 16.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	Policy for UM Policy for exceptions		Full	This requirement is addressed in the Prior Authorization Policy, page 11 and the CCR-OBS Care Policy, page 16.	
8.11	**Medical History Information**					
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making medical necessity determinations.	Policy for UM		Full	This requirement is addressed in the Prior Authorization Policy, page 21 and the CCR-OBS Care Policy, pages 21-22.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	Policy for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the Prior Authorization Policy, page 21 and the CCR-OBS Care Policy, page 22.	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Policy for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the Prior Authorization Policy, page 21 and the CCR-OBS Care Policy, page 22.	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by LDH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	Policy for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the Prior Authorization Policy, page 21 and the CCR-OBS Care Policy, page 22.	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**					
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	PCP/BN profiling report		Full	This requirement is addressed in the QI Program Description on pages 16, 59, and 80-81.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Policy for UM		Full	This requirement is addressed in the QI Program Description on page 25 and in the draft Review of Potential Quality of Care Concerns Policy.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
8.13	**Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay**					
8.13.1	All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.	Evidence of timely submission of profile reports		Full	This requirement is addressed in the Prior Authorization Policy, page 26 and the CCR-OBS Care Policy, page 23.	

Eligibility, Enrollment, and Disenrollment

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
11.11	**Disenrollment**					
11.11.1	Disenrollment is any action taken by LDH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by LDH or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.					
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	Policy for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 1.	
11.11.3	**Member Initiated Disenrollment**					
11.11.3.0	A member may request disenrollment from an MCO as follows:					
11.11.3.1	For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and LDH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs;	Policy for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on pages 3 and 4. That the termination of contract between the MCO and LDH or the end of the contract between member's behavioral health provider and the MCO are causes for disenrollment anytime are not listed in this policy. "Any other reason deemed valid by LDH" is also not listed; if it were, the other causes would effectively fall under this item. The termination of contract between the MCO and LDH is listed as a cause in the member handbook on page 50. Also on this page, the member handbook lists lack of "specialized care" as a cause, which meets the "specialized behavioral health" subpart of this requirement. The handbook also includes "any other reason LDH says counts	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• The member's active specialized behavioral health provider ceases to contract with the MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by LDH and/or its agent.				as a reason," which meets this requirement.	
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).	Policy for Member Disenrollment		Substantial	This requirement is addressed partly in the Member Disenrollment/Disruptive Member Transfer Policy on page 3. The second (90 days following the postmark) and last (sanctions) subparts of this requirement are not addressed in this policy. The former subpart is included in the member handbook on page 50; however, the latter (sanctions) is not. **Recommendation** The MCO should include all reasons for disenrollment without cause in the Member Disenrollment/Disruptive Member Transfer Policy and the member handbook, as appropriate.	MCO will update the Member Disenrollment/Disruptive Policy with all language included in the contract. It will be submitted in the upcoming Policy committee Meeting for approval.
11.11.3.3	The member (or his/her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Policy for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 4 as "verbal or written request."	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Policy for Member Disenrollment		Non-compliance	This requirement was not addressed in any policy or document provided by the MCO. The Member Disenrollment/ Disruptive Member Transfer Policy does not mention the state fair hearing process. The member handbook does not include this requirement.	The Member Disenrollment/Disruptive Member Transfer Policy has been updated and approved in our August Policy Committee Meeting.

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					This requirement was discussed during onsite interviews, and the MCO provided an amended Member Disenrollment/ Disruptive Member Transfer policy with this language added. This amended policy is dated 08/09/2019, which is after the review period. **Recommendation** The MCO should finalize the Member Disenrollment/ Disruptive Member Transfer Policy to include this requirement for the next review period.	
11.11.4	**MCO Initiated Disenrollment**					
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).	Policy for Member Disenrollment Member Notification Letter		Substantial	This requirement is partially addressed in the Member Disenrollment/ Disruptive Member Transfer Policy on pages 4 and 5. The language in the policy does not include pre-existing medical condition, refusal of medical care or diagnostic testing, and attempts to exercise member's right to change PCPs. **Recommendation** The MCO should include in their policies that disenrollment will not be requested due to member's pre-existing medical condition, member's refusal of medical care or diagnostic testing, or member's attempts to change, for cause, their PCP.	The language has been added to our Member Disenrollment/Disruptive Member Transfer Policy and approved in our August Policy Committee Meeting.
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), LDH will ensure that the MCO is not requesting disenrollment for other	Policy for Member Disenrollment		Full	The MCO provided the Member Disenrollment/Disruptive Member Transfer Policy as evidence for this requirement. This policy meets the requirement, as no other reasons are listed for disenrollment request by MCO.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.					
11.11.4.3	The MCO may request involuntary disenrollment of a member if the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to LDH;	Policy for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 5 as "misuse of the system."	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	Policy for Member Disenrollment Member Notification Letter		Substantial	The requirement that the MCO shall notify the member in writing and that notification includes reason for disenrollment request is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 5. That the notification should include the effective date is not included in this policy. **Recommendation** The MCO should include the requirement that these notification letters should include the effective date in their policy.	This information will be added to our Member Disenrollment/Disruptive Member Transfer Policy. It will be submitted in the upcoming Policy committee Meeting for approval.
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	Policy for Member Disenrollment		Minimal	This requirement is not entirely or explicitly addressed in any policy provided by the MCO. That the disenrollment actions will be coordinated only through the broker is indicated in the Member Disenrollment/Disruptive Member Transfer Policy on page 1; however, the information that should be included and that the form should be used are not included in this policy. **Recommendation** The MCO should include this requirement with all its subparts in a policy.	This information will be added to our Member Disenrollment/Disruptive Member Transfer Policy. It will be submitted in the upcoming Policy committee Meeting for approval.

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	Policy for Member Disenrollment		Substantial	This requirement is addressed verbatim in the Member Disenrollment/Disruptive Member Transfer Policy on pages 6 and 7; however, this language was inserted into the policy on 5/21/2019, which is outside the review period. **Recommendation** The MCO should finalize the Member Disenrollment/Disruptive Member Transfer Policy to include this requirement for the next review period.	This information has been added to our Member Disenrollment/Disruptive Member Transfer Policy and was approved in June.
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of LDH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	Policy for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment/Disruptive Member Transfer Policy on page 1, as it states that LDH "has the sole authority to disenroll members."	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.					
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	Policy for Member Disenrollment		Substantial	This requirement is not addressed explicitly in any policy submitted by the MCO. On page 4, the Member Disenrollment/Disruptive Member Transfer states, "Aetna Better Health business application system does not process the disenrollment until the Department sends the disenrollment record on the enrollment file," which implies that the MCO is responsible for the provision of all core benefits and services to the member until	This information has been added to our Member Disenrollment/Disruptive Member Transfer Policy. It was approved in our August Policy Committee Meeting.

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					the member is disenrolled by enrollment broker. This requirement was discussed during onsite interviews, and the MCO provided an amended Member Disenrollment/ Disruptive Member Transfer policy with this language added. This amended policy is dated 08/2019, which is after the review period. **Recommendation** The MCO should finalize the Member Disenrollment/Disruptive Member Transfer Policy to include this requirement for the next review period.	

Marketing and Member Education

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.9	**Written Materials Guidelines**					
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The MCO shall also comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i):					
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: • Flesch – Kincaid; • Fry Readability Index; • PROSE The Readability Analyst (software developed by Educational Activities, Inc.); • Gunning FOG Index; • McLaughlin SMOG Index; or • Other computer generated readability indices accepted by LDH.	P/P for Written Member Materials Guidelines Sample written member materials		Substantial	This requirement is substantially addressed in the Member Materials Standards Policy on page 2. However, this policy does not explain how the reading level is determined. Nor does it include that technical terms will be explained to members. During the previous review, the MCO was advised to incorporate these into their policies. The member handbook explains key healthcare terms on pages 56 to 58. **Recommendation** The MCO should include in their policies how reading level of member materials is determined and that technical terms will be explained to members.	This information will be added to our Member Materials Standard policy and submitted for approval in the upcoming Policy Committee Meeting.
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Minimal	That written materials should be "presented in a format that enhances understanding" is addressed in the Member Materials Standards Policy on page 2; however, the specifics of this requirement are not included in this policy (i.e., minimum font size.) The member materials provided for review by the MCO (member handbook, etc.) have 10pt or larger font.	This information has been added to our New, Existing, and Member Information Policy.

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Recommendation The MCO should include the minimum font size requirements for member materials (with the exception of ID cards) in their policies. **MCO Response:** The MCO provided the New, Existing and Reinstated Member Information policy dated 02/01/2015 on page 3; however, this required language was added after the review period, according to the redline changes and revision history on page 10.	
12.9.3	LDH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.					
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	P/P for Written Member Materials Guidelines P/P for Disclosure of Financial Interest		Full	This requirement is addressed in the Photo and Testimonials Release Forms document on page 1.	
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	P/P for Written Member Materials Guidelines P/P for Compliance with "Person First" Policy Sample written member materials including Member Handbook		Full	This requirement is addressed in the Member Rights and Responsibilities Policy. The member rights and responsibilities are also communicated to the members in the member handbook on pages 15 and 16.	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Substantial	This requirement is addressed in the draft of the Print and Mailing Policy on page 3; however, the language pertaining to this requirement was inserted into this policy on 5/31/2019, after the review period. **Recommendation** The MCO should finalize the draft of the Print and Mailing Policy to include this	The Print and mailing Policy will be submitted for approval at the September 11th ABHLA Policy Committee Meeting.

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
					requirement.	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	P/P for Written Member Materials Guidelines Sample written member materials		Substantial	This requirement is addressed in the draft Print and Mailing Policy submitted by the MCO; however, this language was added to the policy on 6/3/2019, which is after the review period. The MCO provided the 2018 Annual Notice to Members, which is a multi-page document. The MCO name and toll-free number are visible on the front page; however, the mailing address is not displayed anywhere on the document. The member handbook displays the MCO's name and website on the front and back covers; however, the mailing address and the toll free number are not displayed on the covers. The mailing address and the toll free number are listed inside the member handbook, which does not meet this requirement. **Recommendation** The MCO should finalize the Print and Mailing Policy with required language and implement this requirement for all multi-page marketing materials, including the member handbook.	The Print and Mailing Policy will be submitted for approval at the September 11th ABHLA Policy Committee Meeting.
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Interpretation Services		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on pages 4 and 9 and in the Interpreter and Translation Services Policy on pages 3 and 4. The member handbook informs the member of oral and sign interpreter services inside the front cover and on pages 3 and 61. The	

Marketing and Member Education						
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					2018 Annual Notification for Members includes this information on page 1.	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the member handbook on page 17.	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Access to Alternative Forms of Communication		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on pages 4 and 9, on the inside cover of the member handbook, and in the Member Materials Standards Policy on page 2. The member handbook indicates that these services are at no cost to the member.	
12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.					
12.11	**Member Education – Required Materials and Services**					
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	P/P for Member Education P/P for Member Disenrollment P/P for Member Enrollment P/P for Member Re-enrollment		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 2 and in the Member Disenrollment/Disruptive Member Transfer Policy on page 3.	
12.11.3	**Member Materials and Programs for Current Enrollees**					
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general	Link to member portal		Minimal	This requirement is not addressed in any of the policies provided by the MCO. The member portal can be reached at https://www.aetnabetterhealth.com/louisiana/members/portal and provides a link to the secure member portal. The mobile app	The requirement will be included in the Website Development Maintenance Policy, an updated version of this policy with required language will be submitted

Marketing and Member Education						
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	informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;				for smart phones is available and members are informed of this on the "For Enrollees" page of the website. **Recommendation** The MCO should include this requirement in its policies.	to the September 11 ABHLA Policy committee.
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Example of bullets/news letter		Minimal	This requirement is not addressed in any of the policies provided by the MCO. The Spring 2018 and Summer 2018 Newsletters evidence the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	This information will be updated on the Written Member Material Policy and submitted in the next upcoming Policy Committee Meeting.
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Brochures and other examples of literature including EPSTD materials		Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The growth chart and swim lessons flyer provided by the MCO for review evidence the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	The requirement will be included in the Graphic Standards Policy, an updated version of this policy with required language will be submitted to the September 11 ABHLA Policy committee.
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN		Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a diabetes pamphlet, which evidences the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	The requirement will be included in the Graphic Standards Policy, an updated version of this policy with required language will be submitted to the September 11 ABHLA Policy committee
12.11.3.5	Materials focused on health promotion programs	Member education		Minimal	This requirement was not addressed in any	The requirement will be

Marketing and Member Education						
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	available to the members;	materials			of the policies provided by the MCO for review. The MCO provided a swim lessons flyer, which evidences the implementation of this requirement. **Recommendation** The MCO should include this requirement in its policies.	included in the Graphic Standards Policy, an updated version of this policy with required language will be submitted to the September 11 ABHLA Policy committee
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications		Full	The member handbook addresses this requirement on page 38. The MCO provided the annual notice to members and a diabetes pamphlet, which evidence the implementation of this requirement.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications		Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a swim lessons flyer to evidence the implementation of this policy. **Recommendation** The MCO should include this requirement in its policies.	The requirement will be included in the Graphic Standards Policy, an updated version of this policy with required language will be submitted to the September 11 ABHLA Policy committee
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material		Minimal	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided a diabetes education empowerment (DEEP) class flyer to evidence the implementation of this policy. **Recommendation** The MCO should include this requirement in its policies.	The requirement will be included in the Graphic Standards Policy, an updated version of this policy with required language will be submitted to the September 11 ABHLA Policy committee
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or	Example Member education material		Non-compliance	This requirement was not addressed in any of the policies provided by the MCO for review. The MCO provided the Spring/Summer 2019 asthma flyer to	The requirement will be included in the Graphic Standards Policy, an updated version of this

Marketing and Member Education						
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	exacerbations related to that disability or disabilities;				evidence the implementation of this policy; however, this was outside the review period. **Recommendation** The MCO should include this requirement in its policies.	policy with required language will be submitted to the September 11 ABHLA Policy committee
12.11.3.11	Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and	Notification P/P member education		Full	This requirement is addressed in the member Materials Standards Policy on page 2. The MCO also provided examples of communication that would be covered by this element such as changes in the provider network.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P member education		Full	This requirement is addressed in the Member Materials Standards Policy on page 3 and in the Member Communications Policy on page 3.	
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.).	Member Handbook		Full	This requirement is fulfilled by the member handbook, which includes behavioral health benefits.	
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:					
12.12.1.2	Table of contents;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 5 to 7.	
12.12.1.3	A general description about how MCOs operate, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services,	Member Handbook		Full	This requirement is addressed in the member handbook enrollee rights and responsibilities on pages 15 and 16, page 12 ED for non-emergent conditions on page 12, utilization services pages 20 to 27, behavioral health on pages 29 to 33, and PCP selection process and PCP's role as coordinator of	

Marketing and Member Education						
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	and an explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;				services on page 17.	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 49 and 50.	
12.12.1.5	Member's right to select and change PCPs within the MCO and how to do so;	Member Handbook		Full	This requirement is addressed in the member handbook on page 17.	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook		Full	This requirement is addressed in the member handbook on page 17.	
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook		Full	This requirement is addressed in the member handbook on page 15.	
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and LDH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 20 to 43.	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 28 and 29.	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook		Full	This requirement is addressed in the member handbook on page 15.	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 22, 34, 35, and 43.	
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical	Member Handbook		Full	This requirement is addressed in the member handbook on pages 38 and 39.	

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	condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.					
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook		Full	This requirement is addressed in the member handbook on page 41.	
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook		Full	This requirement is addressed in the member handbook on page 18.	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with LDH;	Member Handbook		Full	This requirement is addressed in the member handbook on page 28.	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;	Member Handbook		Full	This requirement is addressed in the member handbook on page 15.	
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook		Full	This requirement is addressed in the member handbook on page 50.	

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12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 45 to 49.	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: o The right to a hearing; o The method for obtaining a hearing; and o The rules that govern representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing a grievance or appeal; • The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: o Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and o The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services must be provided.	Member Handbook		Full	This requirement is addressed in the member handbook on pages 45 to 49.	
12.12.1.20	Advance Directives, set forth in 42 CFR §438. 10 (g)(2) (xii) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law,	Member Handbook		Full	This requirement is addressed in the member handbook on pages 50 and 51.	

Marketing and Member Education						
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	including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.					
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov, or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 3 and 16.	
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Member Handbook		Full	This requirement is addressed in the member handbook on page 18.	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 3 and 11.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 18 to 20.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 20 to 22 and pages 36 and 37.	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a	Member Handbook		Full	This requirement is addressed in the member handbook on page 45.	

Marketing and Member Education						
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	pending personal injury or medical malpractice law suit, or has been involved in an auto accident;					
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	Member Handbook		Full	This requirement is addressed in the member handbook on page 45.	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 15 and 45.	
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish;	Member Handbook		Full	This requirement is addressed in the member handbook in English on pages 15, 16, 60 and 61 and in the member handbook in Spanish on pages 14, 72 and 73.	
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	Member Handbook		Full	This requirement is addressed in the member handbook on page 18.	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to LDH and MCO toll-free numbers and website established for that purpose;	Member Handbook		Full	This requirement is addressed in the member handbook on page 49.	
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook		Full	This requirement is addressed in the member handbook on page 11.	
12.12.1.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed in the member handbook on page 1 as "effective date."	
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.3 (i)]. Service utilization policies; and How to report alleged	Member Handbook		Full	This requirement is addressed in the member handbook on pages 44 (structure and operations of the MCO, policies, physician incentive program) and page 49 (how to report alleged marketing violations).	

Marketing and Member Education						
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	marketing violations to LDH utilizing the Marketing Complaint Form.					
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: • A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers; • General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; • Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and • Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.	Member handbook		Full	This requirement is addressed in the member handbook on pages 29-33.	
12.12.1.36	Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;	Member handbook		Full	This requirement is addressed in the member handbook on pages 28, 44 and 59.	
12.12.1.37	The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:	Member handbook		Full	This requirement is addressed in the member handbook, as detailed in the subparts below.	
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;			Full	This requirement is addressed in the member handbook on page 11, which indicates that the handbook will be mailed to member. The MCO provided Copy of LA_Tracker_-09-12-18 to demonstrate timeliness tracking.	

Marketing and Member Education						
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12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;			Full	This requirement is addressed in the member handbook on page 11, which indicates that the handbook will be mailed to member. During onsite discussion, the MCO indicated that no email requests were received during review period.	
12.12.1.37.3	Posts the information on their member website and advises the member in paper or electronic form that the information is available at the specified web address; or			Full	This requirement is addressed in the member handbook and the member newsletters, which inform members of the member materials (including the member handbook) available online.	
12.12.1.37.4	Provides the information in any other method that can be reasonably expected to result in the member receiving the information.			Full	This requirement is addressed in the member handbook on page 11 and 12 under mobile app, language services, and other ways to get information.	
12.12.1.38	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	Member notification		Minimal	This requirement is not addressed in any policy provided by the MCO. However, the 2018 Annual Notification to Members evidences the implementation of this requirement. The Member Rights and Responsibilities policy states on pages 5-6, "Each subsequent year members are notified of member rights and responsibilities and any changes through the Aetna Better Health website, annual notification and member newsletter."…" Aetna Better Health informs members, providers/practitioners about the availability of member rights and responsibilities documentation online and about the various methods available to contact Aetna Better Health for assistance. If information is posted on the website, Aetna Better Health informs members and practitioners that the	This language will be added to our Member Rights and Responsibilities policy and presented in our September policy review committee.

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					information is available online. Information is mailed to members and providers/practitioners who do not have fax, e-mail or internet access." This does not address the requirement because it does not reference either the Member Handbook or the member Welcome Newsletter, but only rights and responsibilities documentation. **Recommendation** The MCO should include this requirement in their policies about member handbook or welcome newsletter.	
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook		Substantial	The requirement that the member handbook will be updated at least once a year is addressed in the member handbook on page 11. The requirement that the handbook must be submitted for approval to LDH is addressed in the Member Communications Policy on page 3; however, the timeliness requirement (four weeks) is not included. Date of revision is listed as "effective date" on page 1 of the member handbook (September 1, 2018). The MCO provided the New, Existing and Reinstated Member Information policy dated 02/01/2015 on page 3; however, this required language was added after the review period, according to the redline changes and revision history on page 10. **Recommendation** The MCO should finalize the draft of the	This language has been added to our New, Existing, and Reinstated Member Information policy.

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					New, Existing and Reinstated Member Information policy to include this requirement.	
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	P/P for Provider Directory Provider Directory		Full	This requirement is addressed in the Provider Directory Updates Policy on page 3.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	P/P for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed in the Provider Directory Updates Policy on page 3.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)		Substantial	This requirement is mostly addressed in the Provider Directory Updates Policy on page 3; however, that the provider directory online should be "web-based machine readable" is not included in the policy. In the same policy, on page 9, usability testing is addressed, but not for machine readability. The provider directory is online and searchable by members and by the public at https://www.aetnabetterhealth.com /louisiana/members/directory. The MCO provided the Aetna Better Health of Louisiana Website - Provider Search Usability Report. **Recommendation** The MCO should include this requirement in its entirety in its policies.	This information will be updated on the Provider Directory Policy in our next Policy Committee Meeting in September.
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	P/P for Provider Directory Provider Directory (electronic file format)		Full	This requirement is addressed in the Provider Directory Updates Policy on page 3.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	P/P for Provider Directory Provider Directory		Substantial	This requirement is addressed in the Provider Directory Updates Policy on page 3.	Working to create an abbreviated version of the

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		(abbreviated hard copy)			During onsite discussion, the MCO indicated there is no abbreviated version available. **Recommendation** The MCO should make an abbreviated version of the provider directory available.	Provider Directory.
12.14.3	The hard copy directory for members shall be reprinted with updates at monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	P/P for Provider Directory		Full	This requirement is addressed in the Provider Directory Updates Policy on pages 6 to 8.	
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:					
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Substantial	This requirement is addressed in the Provider Directory Updates Policy on page 10. The cultural competency training part of the requirement is addressed on page 5. However, the online provider search does not include information about provider's cultural competency training status. **Recommendation** The MCO should include this information in its online provider search.	This information will be updated on the online provider search.

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;					
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the Provider Directory Updates Policy on pages 3 to 5. Online provider directory meets this requirement.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the Provider Directory Updates Policy on page 4 and in the member handbook on page 17.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the Provider Directory Updates Policy on page 4	
12.17.15	**Members' Rights and Responsibilities**					
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3 and in the member handbook on pages 15 and 16. The provider manual also addresses this requirement on pages 35, 36, and 55 to 58. Sample contracts with providers submitted by the MCO also address this requirement.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 3 and in the member handbook on pages 15 and 16.	
12.17.16	**Member Responsibilities**					
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 5 and in the member handbook on page 16.	
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the	P/P for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed in the Member Rights and Responsibilities Policy on page 5 and in the member handbook on page 16.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.					
12.18	**Notice to Members of Provider Termination**					
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	P/P for Provider Termination P/P for notifying members of provider termination		Full	This requirement is addressed in the Provider Network Voluntary and Involuntary Terminations Policy on pages 5 to 10. The MCO provided sample letters to demonstrate the implementation of this requirement.	
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to	P/P for Provider Termination P/P for notifying members of provider termination		Substantial	This requirement is partially addressed in the Provider Network Voluntary and Involuntary Terminations Policy on page 4 and 10. However, that the notice shall be provided within seven (7) days is not included with regards to prior authorized course of treatment. **Recommendation** The MCO should include the timeliness requirement in its policy.	This information will be updated on the Provider Termination Policy in our next Policy Committee Meeting in September.

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.					
12.19	**Oral Interpretation and Written Translation Services**					
12.19.1	In accordance with 42 CFR §438.10(d) LDH shall provide on its website the prevalent non-English language spoken by enrollees in the state.					
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in the Interpreter and Translation Services Policy on pages 4, 5 and 7. Members are informed of oral interpretation services and how to access them in the member handbook on page 61 in many languages, including Spanish. Also in the member handbook, the members are informed of their right to receive such services free of charge on pages 15 and 16.	
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Substantial	This requirement is addressed in the Interpreter and Translation Services Policy on page 5; however, the percentage indicated in the policy is 5%, not 4%. During onsite discussion, the MCO indicated that an amended policy is currently going through approval. **Recommendation** The MCO should finalize the draft of the Interpreter and Translation Services Policy to include this requirement.	This information has been added to our Interpreter and Translation Services Policy. This was approved in our June Policy Committee Meeting.
12.19.4	Written materials must also be made available in	P/P for Member Rights and		Substantial	This requirement is addressed in the	This information has been

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.	Responsibilities			Interpreter and Translation Services Policy on pages 7 and 8 and in the Member Materials Standards Policy on page 2; however, the font size requirement (18 point) for large print materials is not included in any policy submitted for review. The member handbook includes taglines in 16 languages regarding multi-language interpretation services free of charge to the member on page 61. **Recommendation** The MCO should include this font size requirement in their Member Materials Standards Policy.	added to our Interpreter and Translation Services Policy. This was approved in our June Policy Committee Meeting.

Member Grievance and Appeals

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**					
13.2	**General Grievance System Requirements**					
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted. The MCO shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.2.2	**Filing Requirements**					
13.2.2.1	**Authority to File**					
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.2.3	**Time Limits for Filing** The member shall be permitted to file a grievance at any time. The member must be allowed sixty (60) calendar days from the date on the MCO's notice of action or inaction to request an appeal.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in	P/P for Grievances		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	writing with either LDH or the MCO.					
13.2.4.2	The member or provider may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.	P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.2.4.3	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and paper copies must be provided by the MCO upon request of the member. The MCO shall make all forms easily available on the MCO's website.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.3	**Grievance/Appeal Records and Report**					
13.3.1	The MCO must maintain accurate records of all grievances and appeals in a manner accessible to LDH and available upon request to CMS. A copy of grievances logs and records of disposition of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.3.2	The MCO shall electronically maintain data on grievances/appeals in accordance with the requirements outlined in this section, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; date of	P/P for monthly reporting of grievances and appeals including sample report format		Full	This requirement is addressed in policy LA 3100.70 Member Appeals Aetna also provided copies of reports provided to LDH	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action.					
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	P/P for Adverse Decisions		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.4	**Handling of Grievances and Appeals**					
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:					
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	P/P for Grievances P/P for Appeals Acknowledgement Letter Template Includes Member Grievance & Appeals File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances Aetna's acknowledgement letter was tested for reading level and scored 7 on the Flesch Kincaid scale All aspects of the Grievance and Appeals processes are clearly communicated in the member handbook and the member web portal. **<u>File Review Results</u>** **Grievance Files** Fifteen (15) of Fifteen (15) files met the requirement. **Appeals Files**	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Ten (10) of Ten (10) files met the requirement	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances	
13.4.1.3 13.4.1.3.1 13.4.1.3.2 13.4.1.3.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: • who were not involved in any previous level of review or decision-making; nor a subordinate of any such individual; • who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: o an appeal of a denial that is based on lack of medical necessity, o a grievance regarding denial of expedited resolution of an appeal, o a grievance or appeal that involves clinical issues. • Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.	P/P for Grievances P/P for Appeals Includes Member Grievance File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances **<u>File Review Results</u>** **Grievance Files** Fourteen (14) of the files reviewed were administrative and non-clinical and therefore Not Applicable One (1) of One (1) of remaining file met the requirement.	
13.4.2	**Special Requirements for Appeals** The process for appeals must:					
13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The	P/P for Appeals Member Handbook Confirmation Letter		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.	Template				
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of expedited resolution).	P/P for Appeals Member Handbook Process for notifying member of opportunity to provide evidence Includes Member Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal.	P/P for Appeals Member Handbook Process for notifying member of opportunity to examine case file Includes Member Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	P/P for Appeals Member Handbook Includes Member Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and	Training Agendas and attachments Sign-in sheets		Full	Aetna provided quarterly training attendance sheets and curriculum.	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	providers.					
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Name and title of individual or name of body having decision-making authority Job description for individual having decision-making authority		Full	Aenta identified the Medical Director	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified, the member's request will be deemed to exhaust the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	P/P for Appeals P/P for Fair Hearing Appeal Resolution Notice		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5	**Notice of Action**					
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10 and Section 12 of this RFP to ensure ease of understanding.	Notice of Action Includes Member Grievance and Appeals File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **<u>File Review Results</u>** **Grievance Files** Fifteen (15) of Fifteen (15) files met the requirement. **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:					

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	P/P for Notice of Action Notice of Action Includes Member Grievance and Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Grievance Files** Fifteen (15) of Fifteen (15) files met the requirement. **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.5.2.2	The reasons for the action; including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.5.2.3	The member's right to file an appeal with the MCO;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.2.5	The procedures for exercising the rights specified in this section;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.2.6	The circumstances under which expedited appeal is available and how to request it;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to	P/P for Notice of Action Notice of Action Includes Member Appeal		Substantial	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results**	The letter was updated at the beginning of the year, to include the appropriate language.

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	repay the costs of these services; and	File Review			**Appeals Files** Two (2) of the Ten (10) files reviewed were resolved in the members favor and therefore were Not Applicable Eight (8) of Eight (8) remaining files did not meet the requirement Onsite it was discussed that Aetna's notice after initial prior authorization review does contain the language however the appeal letter does not. **<u>Recommendation:</u>** Aetna should add the explicit instructions on accessing continuous benefits during the State Fair Hearing process to the notice of adverse benefit determination.	
13.5.2.8	Availability of interpretation services for all languages and how to access them.	P/P for Notice of Action Notice of Action		Substantial	Aetna indicated that the required language could be found in Policy 3100.70 Member Appeals, page 7. A full review of this policy revealed "oral interpretation services and alternate formats will be available to members at no cost". On the other hand the section of the policy directly related to the notice of action or decision letter does not mention inclusion of this service as a standard disclosure. **<u>Recommendation:</u>** The language describing the availability of interpretation services should be included in the Notice of Action.	The letter has been updated in to include the required verbiage and sent to the state for review/approval.
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:					
13.5.3.1	For termination, suspension, or reduction of	P/P for Notice of Action		Full	This requirement is addressed in policy LA	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	previously authorized Medicaid-covered services, at least ten (10) days before the date of action,:				3100.70 Member Appeals	
13.5.3.2	In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud at least five (5) days before the date of action;	P/P for Notice of Action		Non compliance	This new language is not yet included in policy LA 3100.70 Member Appeals Onsite, Aetna stated that the requirement is addressed in policy. LA 0041. LA State notification. A review of this policy did not indicate that the required language was contained within. **Recommendation:** Aetna should add the required language to its policies and procedures.	The verbiage is being added to the SIU policy.
13.5.3.3	By the date of action for the following: • In the death of a recipient; • If the member submits a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information); • The recipient's admission to an institution where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or • As otherwise permitted under 42 CFR §431.213.	P/P for Notice of Action		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.3.4	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	P/P for Notice of Action		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.5.3.5 13.5.3.5.1 13.5.3.5.2	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Action P/P for Notice of Action for Standard Service Authorizations P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.3.6	If the MCO extends the timeframe in accordance with above, it must: • Make reasonable efforts to give the member prompt oral notice of the delay; • Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.3.7	On the date the timeframe for service authorization as specified expires. Untimely service authorizations constitute a denial and are thus adverse actions.	P/P for Notice of Action		Full	This requirement is addressed in policy LA Prior Authorization	
13.5.3.8	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision	P/P for Notice of Action P/P for Notice of Action for Expedited Service Authorizations		Full	This requirement is addressed in policy LA Prior Authorization	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.					
13.5.3.9	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.5.3.10	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.					
13.6	**Resolution and Notification**					
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.6.1	**Specific Timeframes**					
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	P/P for Grievances		Full	This requirement is addressed in policy LA 3100.90 Member Grievances	
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	P/P for Appeals Includes Member Appeals File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **<u>File Review Results</u>** **Appeals Files** Ten (10) of Ten (10) files met the requirement	
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended	P/P for Appeals Includes Member Appeals File Review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **<u>File Review Results</u>** **Appeals Files**	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	under Section 13.6.2 of this Section.				Eight (8) of the were Not Applicable due to the fact that there were no expedited appeals Two (2 of Tw0 (2) remaining files met the requirement.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Appeals File review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files were Not Applicable due to the fact that there were no extension requests.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member: • Give the member written notice of the reason for the delay. • Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Appeals File review		Full	This requirement is addressed in policy LA 3100.70 Member Appeals **File Review Results** **Appeals Files** Ten (10) of Ten (10) files were Not Applicable due to the fact that there were no extension requests.	
13.6.3	In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.6.4 13.6.4.1 13.6.4.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance.	P/P for Grievances P/P for Appeals Resolution Notice		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Appeals. For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.					
13.6.5 13.6.5.1 13.6.5.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.	P/P for Appeals Resolution Notice		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances	
13.6.6	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.					
13.6.6.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within one hundred twenty (120) days from the date of the MCO's notice of resolution. The member may also initiate a State Fair Hearing following deemed exhaustion of appeals processes.	P/P for Appeals P/P for Fair Hearings		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.6.6.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	P/P for Fair Hearings		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances	
13.7	**Expedited Resolution of Appeals**					
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	(in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.					
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	P/P for Appeals Provider Handbook		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	P/P for Appeals Denial Notice		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have exhausted the MCO's appeal process as of the date upon which a final determination should have been made.	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.7.4	**Process**	P/P for Appeals		Full	This requirement is addressed in policy LA	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.7.4.1	The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.				3100.70 Member Appeals	
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Process for notifying member of opportunity to present evidence		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	P/P for Appeals		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.8	**Continuation of Benefits**					
13.8.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.					
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii); • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and • The member requests extension of benefits.					
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.9	**Information to Providers and Contractors**					
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(2)(xi) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Manual/Handbook Provider Contract Contractor Contract		Full	This requirement is addressed in provider manual	
13.10	**Recordkeeping and Reporting Requirements**					

Member Grievances and Appeals						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	P/P for Grievances P/P for reporting grievances and resolutions to DHH Report Format		Full	This requirement is addressed in policy LA 3100.70 Member Appeals and in policy LA 3100.90 Member Grievances	
13.11	**Effectuation of Reversed Appeal Resolutions**					
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision..	P&P for effectuation of reversed appeal resolutions		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	P&P for effectuation of reversed appeal resolutions		Full	This requirement is addressed in policy LA 3100.70 Member Appeals	

Quality Management

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**					
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.330(a)(1), to:					
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna participates in PIP projects.	
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.6	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by LDH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.7	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.					
14.1.8	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.9	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.10	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.11	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of LDH.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.12	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided examples of several clinically based safety initiatives such as diabetes control, hospital-acquired conditions, and	

Quality Management						
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	selection of QAPI activities.				breast cancer screening as evidence.	
14.1.13	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.15	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.16	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Feedback reports QAPI work plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.1.17	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH.	Evidence of submission to LDH		Full	This requirement is addressed in email confirmation of transmission of the annual QAPI Program Description to LDH and with the member website, which discusses 2018 QM results and 2019 QM initiatives. Aetna provided a copy of the 2018 QAPI Program Evaluation, which is available through the provider portal, as evidence.	
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to	Clinical guidelines for ADHD Provider education Provider manual		Full	This requirement is addressed in the ADHD clinical practice guidelines and tool kits, as well as on the provider website.	

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	increase the alignment with best practices for ADHD care for all children and particularly for children under age six.					
14.1.19	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	P/P provider oversight Peer review reports		Full	This requirement is addressed in Policy LA QM 63, Reviews of Potential Quality of Care Concerns. Aetna also provided a PQOC Report as evidence,	
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets		Full	This requirement is addressed in PIP collaborative and ITM meeting minutes showing Aetna attendance and participation.	
14.1.21	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided copies of Behavioral Health Utilization Report 318 as evidence.	
14.1.21.1 14.1.21.2	.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. .2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to LDH-OBH on an annual base.	Outcome measures and results BH outcome measures and evidence shared with LDH		Full	This requirement is addressed in the report on antidepressant medication compliance.	
14.2	**QAPI Committee**					
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:					
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either	QAPI Program Description Composition of QAPI		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	

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	the chairman or co-chairman;	Committee				
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.1.5	The MCO shall include LDH representative(s) on the QAPI Committee, as designated by LDH as non-voting member(s).	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Program Description QAPI Work Plan QAPI Committee Description including roles and responsibilities		Full	This requirement is addressed in the QM Committee meeting minutes from quarterly meetings.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description	
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.9	Maintain minutes of all committee and sub-	QAPI Program Description		Full	This requirement is addressed in the	

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	committee meetings and submit meeting minutes to LDH;				LA_MCO_14_QM 2019 Program Description.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management services;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to LDH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	QAPI Program Description QAPI Work Plan Evidence of timely submission of the written QAPI plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.3.6	Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines	QAPI program description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	

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	as appropriate.					
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	Monitoring plan		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to LDH which, at a minimum, shall include: • Quality improvement (QI) activities; • Recommended new and/or improved QI activities; and • Results of the evaluation of the impact and effectiveness of the QAPI program.	QAPI Program Description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided their QAPI evaluations for 2017 and 2018 as evidence.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to LDH using the specifications and format approved by LDH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and LDH.	QAPI Program Description		Full	Aetna provided reports on nursing home, behavioral health, CSoC, SUD, and other populations.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report on performance measures listed in Attachment E and in accordance with the timeline and format specified in the MCO Quality Companion Guide.	HEDIS IDSS results PM results		Full	Aetna provided evidence that all performance measures were submitted on time.	
14.2.5.2	The MCO shall have processes in place to monitor and self-report all performance measures.	P/P performance measures Final audit report		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided a report from their HEDIS auditor as evidence.	
14.2.5.3	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	P/P performance measurement		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided copies of their Clinical	

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					Practice Guideline Policy as evidence.	
14.2.5.4	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	P/P QAPI program description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.5.5	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.	P/P QAPI program description		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan		Substantial	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. A pre-onsite review of the annual 17P measure, as well-as the monthly ITM measures identified variance in monthly versus annual denominators of high risk pregnant women with prior preterm birth. Aetna states the following: "There are historical issues with rate calculation. This is a state measure. Aetna's QI Department did an audit of 17P calculation. Modifications to the logic have been made. Going forward, Aetna is using the Inovalon HEDIS product to eliminate this variance." **Recommendation**: Aetna should move forward with its remediated process and monitor this measure to ensure rate accuracy.	Aetna plans to build a process for validating and verifying data integrity to ensure accurate outcomes. Aetna will also put a regular audit process in place to monitor accuracy. A system such as Inovalon will be utilized to build non-hedis measures or custom measures to eliminate variance. This has been discussed with Aetna corporate as part of HEDIS project activities.
14.2.5.7 14.2.5.7.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Attachment E annotated with "$$".	HEDIS results – incentive measures		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided HEDIS worksheets as evidence. The indicators are now found in Appendix J. Aetna demonstrated the annotation as evidence.	

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14.2.5.7.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below LDH's established benchmarks for improvement.					
14.2.5.7.3	LDH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and LDH will provide six (6) months' notice of such change.	P/P Performance measures		Not Applicable	This is a state function.	
14.2.5.8 14.2.5.8.1	**Performance Measures Reporting** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	HEDIS results IDSS submission Final audit report				
14.2.5.8.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by LDH.			Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description.	
14.2.5.8.3	The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.2.5 Performance Measures.	P/P performance measures		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided self-reported non-HEDIS performance measure reports as evidence.	
14.2.5.9	Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	P/P performance measures		Full	This requirement is addressed in the HEDIS Audit Timeline. Aetna provided the 2018 HEDIS workbook as evidence.	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non-clinical performance measures as specified in 42 CFR §438.330.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the HEDIS Audit Timeline.	
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs	PIP proposal/reports		Full	This requirement is addressed in the	

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	listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. LDH may require up to two (2) additional projects for a maximum of four (4) projects.	P/P performance input projects PIP meeting minutes			required PIP reporting.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional LDH-approved behavioral-health PIP each contract year.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the required PIP reporting.	
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective quality indicators; • Implementation of interventions to achieve improvement in the access to and quality of care; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the required PIP reporting.	
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to LDH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO members and providers; • The study question;	PIP proposal/reports P/P performance input projects PIP meeting minutes		Substantial	With the exception of the IET PIP, Aetna has met all PIP requirements. During the review period, there were two IET PIP components with a determination of Not Met: 2c. Objectives did not align aim and goals with interventions, and 4a. Susceptible subpopulations were not	Aetna has met with IPRO and LDH on 9/3/19 to discuss and clarify goals, objectives and interventions. Aetna is in the process of revising the IET PIP to meet all requirements. The revision will be reflected in the next submission.

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	• The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.				identified using claims data on performance measures, and Stratified by demographic and clinical characteristics. Also during the review period, there was no primary contact person indicated on the IET PIP. **Recommendation:** Aetna should address these issues in their next PIP submission.	Aetna will utilize claims data on performance measures to identify the appropriate population. A primary contact person has been assigned to lead the IET PIP.
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the required PIP reporting.	

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	initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.					
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	CAHPS report		Full	This requirement is addressed in Policy A-LA 8200.10, CAHPS Member Experience Surveys.	
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	CAHPS Vendor contract		Full	This requirement is addressed in the executed contract with Center for the Study of Services to conduct CAHPS surveys.	
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for	CAHPS report		Full	This requirement is addressed in copies of CAHPs reports for adult and child surveys.	

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	each required CAHPS survey. CAHPS survey results are due with all other performance measures.					
14.2.10.5	The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses will be aggregated by LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	CAHPS data file		Full	This requirement is addressed in copies of CAHPs reports for adult and child surveys.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used		Full	This requirement is addressed in copies of CAHPs reports for adult and child surveys.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS reports		Full	This requirement is addressed in copies of CAHPs reports for adult and child surveys.	
14.2.10.8 14.2.10.8.1 14.2.10.8.2 14.2.10.8.3 14.2.10.8.4 14.2.10.8.5	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: .1 Getting Needed Care, .2 Getting Care Quickly, .3 How Well Doctors Communicate, .4 Health Plan Customer Service, .5 Global Ratings.	CAHPS reports		Full	This requirement is addressed in copies of CAHPs reports for adult and child surveys. Aetna provided screen shots as evidence of usage of the current versions.	
14.2.10.9	The MCO's vendor shall perform a LDH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to LDH on an annual basis.	P/P Behavioral health survey Timeline for BH survey administration BH survey results, if administered		Full	This requirement is addressed in an executed contract Aetna provided for Decision Support Systems to provide the adult and children behavioral health survey. Aetna also provided detailed results of the surveys.	
14.4	**Health Plan Accreditation**					
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in Aetna's 2018 NCQA certification with a status of accredited as well as score cards.	

Quality Management						
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14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the confirmation email from NCQA dated April, 24, 2017	
14.4.3	The MCO shall provide LDH with a copy of its most recent accreditation review including:	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the scorecards and other work products of the accreditation.	
14.4.3.1	Accreditation status, survey type, and level (as applicable);	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the 2018 NCQA certification with a status of Accredited, as well as score cards.	
14.4.3.2	Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the 2018 NCQA certification with a status of Accredited, as well as score cards.	
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the 2018 NCQA certification with a status of Accredited, as well as score cards.	
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	Accreditation Status including copy of accreditation report if accredited		Not Applicable	Aetna had full accreditation.	
14.5	**Member Advisory Council**					
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	Member Advisory Council Plan Member Advisory Council Composition Member Advisory Council Description including roles		Full	This requirement is addressed in Policy A-LA 4600-55, Member Advisory Committee. Aetna also provided the Member Advisory Committee (MAC) charter document as evidence.	

Quality Management						
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		and responsibilities				
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council		Substantial	This requirement is addressed in the Member Advisory Committee charter. Aetna provided QAPI meeting minutes that reference the MAC and states that minutes were not kept. **Recommendation:** Aetna should keep minutes of its MAC meetings.	Aetna has started keeping minutes of it's MAC meetings and they will be reported regularly to QMOC for documentation and tracking.
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Member Advisory Council Plan Member Advisory Council Composition		Full	This requirement is addressed in the Member Advisory Committee charter/	
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Member Advisory Council Plan		Substantial	This requirement is addressed in The Member Advisory Committee charter. Aetna provided QAPI meeting minutes that reference the MAC and states that training materials or training agendas are available. **Recommendation:** Aetna should conduct required training and document attendance by MAC members.	Training modules will be developed to orient new MAC members, and for on-going training so Council members can be informed of their responsibilities. Attendance and minutes will be documented.
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan		Full	This requirement is addressed in the Member Advisory Committee charter.	

Quality Management						
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	shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.					
14.5.6.	LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	Member Advisory Council Plan		Substantial	This requirement is addressed in the Member Advisory Committee charter. Aetna provided QAPI meeting minutes that reference the MAC and states that minutes were not posted. **Recommendation:** Aetna should keep and post minutes of its MAC meetings.	Aetna will keep and post minutes of its MAC meetings on ABHLA website for members to access.
14.6 14.6.1	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports.	Fidelity monitoring plan MOUs Evidence of submission to LDH		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided an MOU with Case Western for services. Aetna provided the 2018 Monitoring Plan as evidence. This included ACT, MST, and FFT. Aetna provided reports in LDH format – Report 355 – as evidence.	
14.6.2	The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH specified ACT Monitoring tool.	Fidelity monitoring plan Evidence of submission to LDH		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided signed attestation of training	

Quality Management						
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	The MCO shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.				as evidence.	
14.6.3	A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by LDH. Reports will be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.	Fidelity monitoring plan Site visit reports Evidence of submission to LDH		Full	Aetna provided the 2018 Monitoring Plan. This included ACT, MS,T and FFT. Aetna provided reports in LDH format – Report 355 – as evidence.	
14.8 14.8.1	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by LDH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.	P/P BH reporting Critical incident reporting system		Full	This requirement is addressed in Policy and Procedure A-LA 800.21, Adverse Incident Reporting. Aetna provided their annual Adverse Incident Plan Report 352 as evidence.	
14.8.2	The MCO, as directed by LDH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for					

Quality Management						
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	incident management.					
14.8.3	The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	P/P BH reporting		Full	This requirement is addressed in the annual Adverse Incident Report 326.	
14.9	**Provider Monitoring Plan and Reporting**					
14.9.1	The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:	P/P BH reporting Evidence of report submission to LDH		Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.1	Review criteria for each applicable provider type/level of care;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.2	Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.3	Member interview criteria;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.4	Random audit selection criteria;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.5	Tools to be used;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting. Aetna supplied sample tools as evidence.	
14.9.1.6	Frequency of review, including schedule of reviews by provider type;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.7	Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	`

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14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.1.9	Inter-rater reliability testing methods.			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting. Aetna provided IRR grading for reviewers as evidence.	
14.9.2	At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient /residential. Additional levels of care may be added at the discretion of LDH.	P/P BH reporting		Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3	The MCO's review criteria shall address the following areas at a minimum:	P/P BH reporting				
14.9.3.1	Adherence to clinical practice guidelines;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.3	Cultural competency;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.4	Patient safety;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.5	Compliance with adverse incident reporting requirements;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	

Quality Management						
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	plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and					
14.9.3.8	Continuity and coordination of care, including adequate discharge planning			Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting.	
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.					
14.9.5	The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall	Provider Monitoring P/P		Full	This requirement is addressed in Policy A-LA 8000.63, Provider Monitoring and Reporting. Aetna provided sample CAPs as evidence.	

Quality Management						
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	monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.					
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for Specialized Behavioral Health Services.	Provider Monitoring P/P Provider Monitoring Reports		Full	This requirement is addressed in the quarterly provider monitoring reports in LDH format.	
14.10	**Outcome Assessment for Specialized Behavioral Health Services**					
14.10.1	The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.	BH outcome assessment plan Assessment Reports		Full	This requirement is addressed in the LA_MCO_14_QM 2019 Program Description. Aetna provided multiple examples of reporting on the specialized behavioral health population as evidence.	
14.10.2	The MCO shall ensure providers and appropriate MCO staff are adequately trained/ certified in the use of such tools and such training/certification is current.	BH outcome assessment plan Training materials Evidence of Training Attendance		Full	This requirement is addressed in the web-based training links. Aetna provided training slides and sign-in sheets as evidence.	
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.	BH outcome assessment plan		Full	This requirement is addressed in the multiple examples of reporting on the specialized behavioral health population Aetna provided.	

Fraud, Abuse, and Waste Prevention

Fraud, Abuse, and Waste Prevention						
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15.1	**General Requirements**					
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act..					
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with LDH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at LDH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided quarterly meeting minutes as evidence.	
15.1.3	The MCO and its subcontractors shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years from the expiration date of the Contract (including any extensions to the Contract), or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.					
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, LDH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.5	The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained.					
15.1.6	The MCO and its providers and subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.7	MCO's employees consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	proceedings, pre-trial conferences, hearings, trials, and in any other process.					
15.1.8	The MCO and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.9	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and LDH policy.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.10	The MCO will report to LDH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated LDH Program Integrity contact.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.11	The MCO and its subcontractors shall have surveillance and utilization control programs and procedures pursuant to (42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall	FWA Compliance Plan Network Provider		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.	Enrollment & Disclosure Forms				
15.1.13	The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms Employee Disclosure Forms		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Service Agreement.	
15.1.14	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 50,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. There are four investigators in LA. There are approximately 114, 000 members. One supervisor is AFI-certified.	

Fraud, Abuse, and Waste Prevention						
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	Integrity Officer and must be located in-state. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.					
15.1.15	LDH or its designee will notify the MCO when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.15.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.15.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.16	The prohibition described above in Section 15.1.15 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to LDH.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.17	The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see	FWA Compliance Plan Payment Suspension P/P		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..					
15.1.18	**Reporting and Investigating Suspected Fraud and Abuse**					
15.1.18.1	The MCO and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.					
15.1.18.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.3	The MCO shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.4.1	All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month) shall be reported to LDH Program Integrity monthly; LDH	FWA Compliance Plan Evidence of report submission		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.4.2	Suspected fraud and abuse in the administration of the program shall be reported to LDH Program	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	Integrity and MFCU;					
15.1.18.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH Program Integrity and MFCU; and	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence..	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.5	When making a referral of suspected fraud, the MCO shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of this Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form	FWA Compliance Plan Provider referral forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided a referral form template as evidence.	
15.1.18.6	The MCO shall be subject to a civil penalty, to be imposed by the LDH, for willful failure to report fraud and abuse by employees, subcontractors, beneficiaries, recipients, enrollees, applicants, or providers to LDH MFCU, as appropriate.					
15.1.18.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.1.18.8	The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.9	The MCO and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.18.10	The MCO and/or its subcontractors are to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.19	The State shall not transfer its law enforcement functions to the MCO.					
15.1.20	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	FWA Compliance Plan Provider Agreement Form		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Service Agreement.	
15.1.21	The MCO shall notify LDH when the MCO or its subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the	FWA Compliance Plan Provider Enrollment, Disclosure & Credentialing Forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	ability of providers to participate in the program for program integrity reasons.					
15.1.22	The MCO shall report overpayments made by LDH to the MCO within 60 calendar days from the date the overpayment was identified.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.1.23	Unless prior written approval is obtained from LDH, the MCO shall not employ extrapolation methods to derive an overpayment in a provider audit..	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2	**Fraud and Abuse Compliance Program**					
15.2.1	In accordance with 42 CFR §438.608(a), the MCO and its subcontractors, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the MCO and the state, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the MCO's compliance program shall designate a contract compliance officer who is responsible for developing and implementing written policies, procedures, and standards to ensure compliance with the requirements of this contract and all applicable Federal and State requirements, and who reports directly to the CEO and board of directors. .	FWA Compliance Plan		Full	This requirement is addressed in the Policy A-LA 3000.02, Compliance Manager Designation.	
15.2.3	The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer	FWA Compliance Plan PI Org chart and resumes		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.2.4	The MCO shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under the contract.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6	In accordance with 42 CFR 438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.	FWA Compliance Plan Compliance Committee Charter Compliance Committee meeting minutes		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided the ABHLA Compliance Committee Charter as evidence.	
15.2.6	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to LDH for approval at least thirty (30) days in advance of making them effective. LDH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	FWA Compliance Plan		Full	This requirement is addressed in the email documenting the submission of the 2018 Compliance Plan.	
15.2.6.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;			Full	This requirement is addressed in Policy 002 MCD SIU Overview.	
15.2.6.2	Effective lines of communication between the Contract Compliance Officer and the MCO's employees, providers and contractors			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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15.2.6.3	Enforcement through well-publicized disciplinary guidelines;			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6.4	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6.5	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;			Full	This requirement is addressed in Policy A-LA 3000.12, Reporting Compliance Issues or Inquiries.	
15.2.6.6	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);			Full	This requirement is addressed in Policy A-LA 3000.41, Compliance Review and Monitoring.	
15.2.6.7	Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.			Full	This requirement is addressed in Policy A-LA 3000.12, Reporting Compliance Issues or Inquiries.	
15.2.6.9	Procedures for prompt notification to LDH when the MCO receives information about			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	changes in a member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.					
15.2.6.10	Procedures for prompt notification to LDH when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6.11	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6.12	Effective training and education system for the Contract Compliance Officer, program integrity investigators, managers, and members to ensure that they know and understand the federal and state standards and requirements of MCO's contract;			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.2.6.13	Fraud, Waste and Abuse Training shall include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.			Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided training sign in sheets.	
15.2.6.14	The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse identification and reporting procedures • Federal False Claims Act and employee whistleblower protections • Procedures for timely consistent exchange of			Full	This requirement is addressed in the 2018 ABHLA Compliance plan. Aetna provided training slides as evidence.	

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	information and collaboration with LDH; • Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.					
15.2.7	The MCO shall require and have procedures for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	Overpayments Policy Overpayments notice form		Full	This requirement is addressed in Policy AMA 3900.30, Reporting and Return of Overpayments.	
	The MCO shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.	Overpayments Policy		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.3	**Prohibited Affiliations**					
15.3.1	In accordance with 42 CFR 438.610, the MCO and its subcontractors are prohibited from knowingly having a relationship with: An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive					

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Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Order No. 12549 or under guidelines implementing Executive Order No. 12549.					
15.3.4	The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR 438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation.. The MCO and its subcontractors shall screen all employees and contractors and network providers to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided the addendum to their provider agreement, which pushes the exclusions requirements down to providers, as evidence. Aetna provided quarterly FWA Report 145, which includes disclosure of LEIE matches, as evidence. Aetna provided additional evidence of employee screening.	
15.3.5	The MCO shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); • Louisiana Adverse Actions List Search; • The System of Award Management (SAM); and • Other applicable sites as may be determined by LDH	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.3.6	The MCO and its subcontractors shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	

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	even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).					
15.3.6.1	An individual who is an affiliate of a prohibited person or entity described above include: • A director, officer, or partner of the MCO; • A subcontractor of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations under this contract. • A network provider.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.3.6.2	The MCO shall notify LDH in writing within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.3.7	The MCO, through its Contract Compliance	FWA Compliance Plan		Full	This requirement is addressed in the 2018	

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	Officer, shall attest monthly to LDH that a search of the websites referenced in 15.3.5 been completed to capture all exclusions.	Copies of monthly reports			ABHLA Compliance Plan. Aetna provided copies of monthly attestations as evidence.	
15.4	**Payments to Excluded Providers**					
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services ; and	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.4.2	The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.5	**Reporting**					
15.5.1	The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.5.2	The MCO shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, subcontractor or subcontractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO, network provider or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.5.3	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:					
15.5.3.1	Number of complaints of fraud, abuse, waste,	FWA Compliance Plan		Full	This requirement is addressed in the 2018	

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Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	neglect and overpayments made to the MCO that warrant preliminary investigation (under 42 CFR 455.14);				ABHLA Compliance Plan. Aetna provided quarterly reports as evidence.	
15.5.3.2	Number of complaints reported to the Contract Compliance Officer; and	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.5.3.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide LDH, at a minimum, the following: • Provider name and ID number; • Source of complaint; • Type of complaint; • Nature of complaint; • Approximate range of dollars involved if applicable; and • Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.5.3	The MCO, through its compliance officer, shall attest to LDH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	FWA Compliance Plan Attestation Form		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided attestations as evidence.	
15.5.4	The MCO shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)] .	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided quarterly reports as evidence.	
15.5.5	The MCO shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna provided quarterly reports as evidence.	
15.5.6	LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42					

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	CFR §438.608(d)(4).					
15.6	**Medical Records**					
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members as billed. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	P/P for medical records P/P for medical record documentation standards P/P for medical record monitoring Provider Manual Model Provider Contracts for all provider types		Full	This requirement is addressed in the verification of service requests Aetna includes in EOB mailings to members. Also, Aetna has a claims sampling report based on EOB letters.	
15.6.1.1	Accurate and legible;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or	P/P for medical records P/P for medical record		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services	

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	dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	standards			Agreement.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.7	Signed and dated consent forms (as applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.8	Documentation of immunization status;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.9	Documentation of advance directives, as appropriate;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	

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15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	P/P for medical records		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.6.4	All documentation and/or records maintained by the MCO its subcontractors, and all of its network providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	P/P for medical records P/P for medical record retention		Full	This requirement is addressed in the Aetna Better Health of Louisiana Facility Services Agreement.	
15.7	**Rights of Review and Recovery by MCO and LDH**					
15.7.1	The MCO and its subcontractors is responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract,.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.2	The MCO and its subcontractors shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. The MCO shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.3	All reviews shall be completed within eight	FWA Compliance Plan		Full	This requirement is addressed in the 2018	

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	months (240 calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.				ABHLA Compliance Plan.	
15.7.4	The MCO shall confer with LDH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by LDH.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.5	Contact with the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.6	If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of the Department approved proceeding with the recoupment (per 15.1.17), unless an extension or exception is authorized by the Department, or the MCO has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, the Department or its agent may recover the overpayment from the MCO and said funds will be retained by the State. Exception reasons may include, but are not limited					

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	to, MCO cooperation with LDH or other government agencies, termination of provider participation with the MCO, or dissolution of the provider's business.					
15.7.7	LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. LDH may recover from the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.8	LDH shall not initiate its own review on the same claims for a network provider which has been identified by the MCO as under a review approved by LDH per Section 15.7.4. LDH shall track open LDH and MCO reviews to ensure audit coordination. LDH shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.					
15.7.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.10	In the event the State or its agent investigates or	FWA Compliance Plan		Full	This requirement is addressed in the 2018	

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	audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.				ABHLA Compliance Plan.	
15.7.11	LDH shall notify the MCO and the network provider concurrently of overpayments identified by the State or its agents.					
15.7.12	The MCO shall not correct claims not initiate an audit on the claims upon notification of identified overpayment by the Department or its agent unless directed to do so by the Department.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.13	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected . Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
15.7.14	In the event LDH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH.					

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15.7.15	The MCO and its subcontractors shall enforce LDH directives regarding sanctions on MCO network providers and members, up to termination or exclusion from the network.	FWA Compliance Plan		Full	This requirement is addressed in the Louisiana Medicaid Regulatory Compliance Addendum.	
15.7.11	There will be no LDH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Medicaid Managed Care Contract period of for providers for which no MCO relationship existed.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
	Additional PE-Related RFP Sections					
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement was evaluated elsewhere in the tool.	
4.1.4	The MCO shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request,	FWA Compliance Plan		Full	This requirement was evaluated elsewhere in the tool.	

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	provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.					
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. LDH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	FWA Compliance Plan		Full	This requirement is addressed in ABHLA Report PF 015.	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement was evaluated elsewhere in the tool.	
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	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement was evaluated elsewhere in the tool.	

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	participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.					
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).	FWA Compliance Plan		Full	This requirement was evaluated elsewhere in the tool.	
17.2.6.1.9	**Provider Validation–** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to LDH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	FWA Compliance Plan		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to LDH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna had no significant transactions.	

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	18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.					
18.3	**Report of Transactions with Parties in Interest –** 18.3.1 The MCO shall report to LDH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan. Aetna did not have any transactions of this type.	

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	18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.					
18.7	The MCO shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the 2018 ABHLA Compliance Plan.	
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to non-procurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank	FWA Compliance Plan		Full	This requirement was evaluated elsewhere in the tool.	

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	(HIPDB) • http://www.npdb-hipdb.hrsa.gov/index.jsp; • the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.LDH.la.gov/; and/or • the System for Award Management, http://www.sam.gov .					
25.13.2	The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to LDH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).	FWA Compliance Plan		Full	This requirement was evaluated elsewhere in the tool.	
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual;	FWA Compliance Plan				

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	Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.					

Reporting

Reporting						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.242)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
18.0	**Reporting**					
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	Screen shot of health informatics system System reports	-	Full	This requirement is addressed in the screen shots Aetna provided of the Case Trakker and QNXT systems with links for Grievances, Appeals, enrollment, case management, and claims.	