Louisiana Healthcare Connections

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

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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 Louisiana Healthcare Connections (LHCC).

Audit Overview

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

The audit included a comprehensive evaluation of LHCC's policies, procedures, files, and other materials corresponding to the following nine 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 LHCC a packet that included the review tools, along with a request for documentation and a guide to help MCO staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure 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 LHCC on July 15 and 16, 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	113	2	0	0	0	98%
Provider Network Requirements	184	172	12	0	0	0	93%
Utilization Management	87	83	2	0	2	0	95%
Eligibility, Enrollment, and Disenrollment	13	13	0	0	0	0	100%
Marketing and Member Education	83	78	1	0	0	4	99%
Member Grievance and Appeals	65	61	4	0	0	0	94%
Quality Management	114	112	1	0	0	1	99%
Fraud, Abuse, and Waste Prevention	118	118	0	0	0	0	100%
Reporting	1	1	0	0	0	0	100%
TOTAL	**780**	**751**	**22**	**0**	**2**	**5**	**97%**

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

As presented in **Table 3**, 780 elements were reviewed for compliance. Of the 780, 751 were determined to fully meet the regulations, while 22 substantially met the regulations, and 2 were non-compliant. Five elements were "not applicable." The overall compliance score for LHCC was 97% 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 LHCC submit a corrective action plan for each of the 24 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that LHCC 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. More than half of the issues noted related to LHCC's provider network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas–a problem prevalent in the Louisiana Medicaid Managed Care program. Though there were only four elements in the Utilization Management (UM) domain that did not achieve full compliance, two that related to concurrent utilization review were determined to be non-compliant and two that were substantially compliant related to UM file review issues. The MCO should ensure that their policies referencing concurrent utilization review are updated to reflect the contract requirement and that staff receive education in properly notifying providers regarding UM decisions and in the timing requirements of informal reconsiderations.

Each of the nine review tools and review determinations for each of the 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: 438.114, 438.208)**	**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**
Core Benefits and Services					
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	Substantial	This requirement is partially addressed in the Care Plan Development and Implementation and Care Management Program Description Policies; however these policies do not include the part of the requirement addressing "at the request of the member". LHCC did provide examples of this part of the requirement being implemented, but a policy including this was not furnished. **File Review Results** Seven (7) 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, monitoring of outcomes with treatment was revised as indicated per care coordination notes or care plan documentation for all 10 files. 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. **Recommendation** The MCO should ensure that all parts of this requirement are addressed within policy, even if it is a noted practice. Additionally, LHCC should make improvements in care management to	We will add this verbiage to the policy "at the request of the member" and bring through our next scheduled policy committee meeting on 9/24/19 for approval. We will also continue to conduct monthly quality audits to ensure sufficient timeframes for care plan follow up review as well as provide additional information to staff.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**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**
				ensure that care plans are used to monitor and communicate member outcomes, at the very least on an annual basis.	
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	Substantial	This requirement is addressed in the Continuity and Coordination of Services Policy. **File Review Results** Nine (9) 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. **Recommendation** The MCO should develop a review process to ensure that all members have a source of primary care and such care is documented in the case notes:	We are working toward retraining our staff to ensure all members have a current PCP and such is documented. We will work to have all training completed by the end of the 3rd quarter
Provider Network 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-	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the Network Adequacy Policy on pages 14 and 15 under Timely Access Exceptions. The medical provider and BH GeoAccess reports implement the maximum time/distance requirements. Access to some provider types in urban and rural areas do not meet the maximum time/distance The network analysis gap report for 2019 Q1 evidences ongoing monitoring of existing	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	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.			gaps. The MCO has 100% of available Medicaid providers enrolled in most parishes and has ongoing efforts to attract additional providers. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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 Network Adequacy Policy on pages 4 and 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban parishes had access to all PCPs, adult PCPs, and pediatric PCPs statewide. Not all members in rural parishes had access to all PCPs and adult PCPs statewide. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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.	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is addressed in the Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements on pages 17 and 27. The MCO reports that it has 100% of available acute inpatient facilities under contract.	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	• Travel distance for members living in urban parishes shall not exceed 10 miles.			**Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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 Network Adequacy Policy on pages 6, 7, 10 and 11. The medical provider GeoAccess reports implement the maximum time/distance requirements. All members had access to most specialists within 90 miles, except for access to endocrinologists, to whom only 88.9% of members had access within 90 miles. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban	Network Provider Development and Management Plan	Substantial	This requirement is addressed in the Network Adequacy Policy on page 5. The medical provider GeoAccess reports	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**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; and • Travel distance shall not exceed 30 miles for rural parishes.	Policy for Access and Availability GeoAccess reports Requests for exceptions		implement the maximum time/distance requirements. Not all members in urban and rural parishes had access to radiology services within 20 and 30 miles, however rates were 99.5% urban and 94.5% rural. Not all members in had access to lab services within the required limits however rates were 99.5 urban and 99.9 rural. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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 Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban and rural parishes had access to pharmacies within 10 and 30 miles, respectively. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports	Substantial	This requirement is addressed in the Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	areas.	Requests for exceptions		Not all members in urban and rural parishes had access to hemodialysis center within 10 and 30 miles, respectively. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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	Substantial	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports implement this requirement. Fewer than 80% of adult members in urban and rural parishes had access to ASAM Level 3.3 within 30 miles or 60 minutes. The MCO states that ASAM access is an issue throughout the state. Not all facilities accept Medicaid. The MCO monitors the networks of other MCOs in the state to see if there are any not yet in the MCO network so it can attempt to enroll these facilities. They also enter into single case agreements where possible. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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	Network Provider Development and Management Plan Policy for Access and	Substantial	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports implement this requirement.	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Availability GeoAccess reports Requests for exceptions		Over 90% of adult members in urban parishes had access to ASAM Level 3.5 within 30 miles or 60 minutes; however, fewer than 60% of adult members in rural parishes had access to these services within these parameters. Over 90% of pediatric members had access to these services within 60 miles or 90 minutes. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	
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 addressed in the provider manual on page 44; however, cognitive disability is not included in this language. **Recommendation** The MCO should add "cognitive" to the language addressing this requirement in their policies.	Marketing has added this language to Provider Manual and will submit to LDH for approval by 09/27/2019.
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 room services, inpatient, and	Policy for Provider Network GeoAccess reports	Substantial	This requirement is addressed in the Network Adequacy Policy on pages 12 and 13. The GeoAccess reports evidence the implementation of this requirement. As	We, LHCC will continue in our efforts at expanding our network consistently

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**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**
	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.			reported above there are minor coverage gaps across the provider network. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	
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	Substantial	This requirement is addressed in the member handbook on pages 34 and 35; however, the time requirement is not included. **Recommendation** The MCO should add the time frame for selection to the member handbook.	We will ensure our Member's Handbook is updated to add the time frame for selection and will be sent to LDH for approval by 09/13/2019. Once approved, we will post the new version of the handbook on the website and begin production on hard copies.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**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**
Utilization Management					
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision 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.	P/P for UM P/P for notice timing Includes UM File Review	Substantial	This requirement is addressed in the Adverse Determination Notices Policy and demonstrated in the administrative provider denial letter example. **File Review Results** Eight (8) out of ten (10) Utilization Management files reviewed met the provider notification requirements. Two (2) out of ten (10) Utilization Management files reviewed did not meet provider notification requirements. One (1) file reviewed contained no notifications, and in one (1) file, the provider was verbally notified in two (2) business days, which exceeds the requirement. **Recommendation** The MCO should ensure that all provider notification requirements are executed within the appropriate timeframes.	We will provide education and training to our staff to ensure that all provider notification requirements are executed within the appropriate timeframes, all training will be completed by 09/30/2019.
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	P/P for UM P/P for informal reconsideration P/P for notice timing Includes Informal Consideration File Review	Substantial	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy. **File Review Results** Four (4) out of five (5) Informal Reconsideration files reviewed met the one (1) day requirement. One (1) file reviewed was outside the one (1) day requirement. **Recommendation** The MCO should ensure that all informal	We will provide education and training to our staff to ensure that all informal reconsideration requirements are executed within the appropriate timeframes completed by 9/30/19.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	available within one (1) working day.			reconsideration requirements are executed within the appropriate timeframes.	
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.	P/P for UM	Non-compliance	This requirement is not addressed - the MCO states they do not have a policy regarding this element as they consider this a reporting element. Additionally, the documentation provided after the review did not contain this requirement. **Recommendation** The MCO should ensure that this requirement is included in their policies regarding concurrent utilization reviews.	We will update LA.UM.01 to include RFP verbiage regarding concurrent utilization reviews as requested by IPRO and bring through the next policy committee meeting on 9/24/2019 for approval.
8.4.5.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The	P/P for UM Evidence of timely submissions Notification communication to member/provider	Non-compliance	This requirement is not addressed in any of the policies or documents provided by the MCO – all of the policies provided were in regards to procedures for a crisis call center. **Recommendation** The MCO should ensure that this requirement is included in their policies regarding provision of Emergency Inpatient Hospital Psychiatric Screen and concurrent utilization review.	We will update LA.UM.01 to include RFP verbiage regarding provision of Emergency Inpatient Hospital Psychiatric Screen and concurrent utilization review as requested by IPRO and bring through the next policy committee meeting on 9/24/2019 for approval.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	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				

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	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
	in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the				

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	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.				
Marketing and Member Education					
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	Substantial	The first part of this requirement is addressed in the member handbook on page 25. The importance of canceling or rescheduling appointments is not mentioned in the handbook. **<u>Recommendation</u>** The MCO should include this requirement in its entirety in the member handbook.	We are updating our Member Handbook to fully address canceling/rescheduling instead of being a "no show" and will submit to LDH for approval by 09/13/2019. Once approved, we will post the new version of the handbook on the website and begin production on

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					hard copies.
Member Grievance and Appeals					
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	Substantial	This requirement is substantially addressed in LA.QI.11.02 Grievance Process. The member handbook appropriately conveys the 60-day timeframe on page 49; however, the appeal form on page 72 indicates the following: "To file a grievance or appeal, please complete this form and send it to us within 30 days of the event or denial letter." This guidance should reflect the 60 days as outlined in the requirements. **Recommendation** LHCC should ensure consistency throughout the member handbook by indicating the 60-day timeframe in the grievance and appeal form on page 72.	We will show consistency by updating the member handbook to reflect the 60 day timeframe in the grievance and appeal form on page 72; and will submit to LDH for approval on 09/13/2019. Once approved, we will post the new version of the handbook on the website and begin production on hard copies.
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 File Review and Member Appeal File Review	Substantial	This requirement is addressed in LA.QI.11.02 Grievance Process. **File Review Results** Fourteen (14) of 15 grievance files and 10 of 10 appeal files met this requirement. One grievance file demonstrated that the member was given verbal acknowledgement within five days; however, written acknowledgement was issued in seven days.	We have a monthly acknowledgement letter audit program in place with consequences.

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				Recommendation LHCC should ensure timely written communication is issued to members following receipt of grievance.	
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 File Review and Member Appeal File Review	Substantial	This requirement is addressed in LA.QI.11.02 Grievance Process and evidenced in the Notice of Action letter. **File Review Results** Fourteen (14) of 15 grievance files and 10 of 10 appeal files met this requirement. One grievance file indicated that the member's PCP was "termed" and that was why they no longer could see that provider. **Recommendation** LHCC should ensure the reading level of the Notice of Action letter is appropriate to facilitate ease of understanding.	Education email sent to all Clinical Appeal Coordinators citing Audit Element UM 9D providing instruction to always provide specific reason for the appeal decision in easy understandable language. Accreditation SharePoint site has some useful tools: https://cnet.centene.com/sites/Accreditation Please utilize the Medical Terminology in 6th Gr Language to ensure letters are in understandable language. This area is HIGHLY scrutinized. Education email sent to all Grievance and Appeal Coordinators showing the recommendation from IPRO to ensure all acknowledgement and resolution letters are easily read and in a 4th grade level. Teamed with marketing who are currently revamping our letters and will incorporate prefilled drop down boxes with common grievance received.

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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	Substantial	This requirement is partially addressed in LA.QI.11.02 Grievance Process. During onsite interviews, it was determined that LHCC needs to revise policy LA.QI.11.03 Appeals Process so that it includes the required language. That policy has been updated as of August 2019 and submitted for review. **Recommendation:** LHCC should finalize this updated version of the Appeals process policy and distribute to staff as appropriate.	The Appeals Process policy, LA.QI.11.03 was revised to include the wording from the RFP on August 26th & has already been approved by the state.
Quality Management					
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	Substantial	This requirement is evidenced in the 2019 Population Analysis Report. This requirement is partially addressed in the QAPI Program Description on page 1, which states that "Louisiana Healthcare Connections incorporates all demographic groups. . . in its quality improvement activities." The methodology utilized for collecting these data, as well as actions taken to enhance accuracy, are not evident. In our onsite interview, LHCC provided specific examples of how they use data to identify quality gaps and improvement opportunities (i.e., CLASS Committee looks at HEDIS data and breakdown by region, age group, ethnicity, etc. and identified gaps, found issues with	Verbiage will be added to the Quality Program Description to describe the methodology for stated demographic data and the ways these data inform the decisions made in targeting our quality initiatives to specific identified needs as requested by IPRO and we will present at our next QAPIC committee on 9/27/2019 for approval.

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				Vietnamese community, and created intervention focused on these groups). **Recommendation** LHCC should ensure that their QAPI Program Description includes their methodology for collecting demographic data, as well as the ways these data inform the decisions made in targeting their quality initiatives to specific identified needs.	

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						
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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		Full	This requirement is addressed in the Permanent Supportive Housing Policy and	

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		Policy for member education			the PSH Member Outreach Example Document.	
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 Permanent Supportive Housing Policy and additional documents provided by LHCC on-site.	
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 additional documentation provided by LHCC on-site.	
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 by the Permanent Supportive Housing Policy and the additional documentation provided by LHCC on-site.	
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 PSH Liaison Document and the additional documents provided by LHCC on-site.	
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 PCP Toolkit Behavioral Health Document, IPAT Decision Tree Provider BH Resource Document, and LA Medicaid Louisiana Integrated Healthcare Provider Training Document.	
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	Provider handbook Provider education materials Provider contracts Policy for provider education		Full	This requirement is addressed in the PCP Toolkit Behavioral Health Document, IPAT Decision Tree Provider BH Resource Document, the provider manual, and LA Medicaid Louisiana Integrated Healthcare Provider Training Document.	

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	experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.					
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 Coordinated System of Care 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	In folder: 7_ProviderNetwork: LHCC Provider Manual_AllAnnotations.pdf , pg. 144 & 145	Full	This requirement is addressed in the provider manual and examples of communication provided by LHCC on-site.	
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,	Member handbook Policy for ER services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services Policy and member handbook.	

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	be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.					
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 Emergency and Post-Stabilization Services Policy and 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 Emergency and Post-Stabilization Services Policy and member handbook.	
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 Emergency and Post-Stabilization Services Policy and 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	Policy for Coordination of services Communications to hospital		Full	This requirement is addressed in the Emergency and Post-Stabilization Services Policy and provider handbook.	

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	concerning discharge or transfer following an inpatient admission once the member is stabilized.					
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to 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.	Policy for Coordination of Services Quality of core plan Member handbook		Full	This requirement is addressed in the member handbook, provider manual, and the Emergency Department Diversion 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 member handbook, provider manual, and the Emergency Department Diversion Policy.	
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 Emergency Department Diversion Policy and the provider 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 LHCC UM Program Description Policy and the member handbook.	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR					

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	§422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:					
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services 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 Emergency and Post-Stabilization Services 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 Emergency and Post-Stabilization Services 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 Emergency and Post-Stabilization Services 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 Emergency and Post-Stabilization Services Policy.	
6.8.2.2.2	A network physician assumes responsibility for the	P./P post stabilization		Full	This requirement is addressed in the	

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	member's care through transfer;	services			Emergency and Post-Stabilization Services 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 Emergency and Post-Stabilization Services Policy.	
6.8.2.2.4	The member is discharged.	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services Policy.	
6.19	**Services for Special Populations**					
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:					
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;					
6.19.1.2	Individuals with intravenous drug use;					
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders 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;					

Core Benefits and Services						
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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 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	HRA Policy for members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the Care Management Program Description Policy and the LHCC PASSR quarterly reports. **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. Regarding the requirement for an individual needs	

Core Benefits and Services						
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	treatment or regular care monitoring as appropriate shall result in a referral for case management.				assessment, there were nine (9) applicable files (excluding 1 PASRR/OASS placement case). Nine (9) of 9 applicable files met the requirement for an individual needs and diagnostic assessment. Three (3) of the 3 applicable files were enrolled in CsOC.	
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 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.	Policy for members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the Care Management Program Description Policy. **File Review Results** None (0) of the 10 case management files had a documented referral source of Special Health Care Needs. None (0) of the 10 behavioral health case management files were documented as SHCN per the LHCC method of identification using the referral source.	
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 Care Plan Development and Implementation and Care Management Program Description Policies. **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	

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					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. Nine (9) of 9 applicable files met the requirement for crisis planning.	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Treatment plan Policy for Individual Treatment Plans Documentation of communication Includes Case Management File Review		Full	This requirement is addressed in the Care Plan Development and Implementation Policy and Care Management Program Description 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		Substantial	This requirement is partially addressed in the Care Plan Development and Implementation and Care Management Program Description Policies; however these policies do not include the part of the requirement addressing "at the request of the member". LHCC did provide examples of this part of the requirement being implemented, but a policy including this was not furnished. **File Review Results**	We will add this verbiage to the policy "at the request of the member" and bring through our next scheduled policy committee meeting on 9/24/19 for approval. We will also continue to conduct monthly quality audits to ensure sufficient timeframes for care plan follow up review as well as

Core Benefits and Services						
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					Seven (7) 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, monitoring of outcomes with treatment was revised as indicated per care coordination notes or care plan documentation for all 10 files. 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. **Recommendation** The MCO should ensure that all parts of this requirement are addressed within policy, even if it is a noted practice. Additionally, LHCC should make improvements in care management to ensure that care plans are used to monitor and communicate member outcomes, at the very least on an annual basis.	provide additional information to staff.
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 Care Plan Development and Implementation and Care Management Program Description Policies, as well as the Care Plan Example document.	
6.28	**Care Management**					

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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 Care Management Program Description Policy and the member handbook.	
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 provider manual and the Care Management Program Description Policy. **<u>File Review Results</u>** 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. Ten (10) of 10 behavioral health case management files met the requirement for recording the member's PCP in the care 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 in the Member Service Calls/Hotline Policy and in the Notification of 24 Hour Nursing Services Documentation.	
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of	CM records Policy for care coordination		Full	This requirement is addressed in the Care Management Program Description and Care Plan Development and Implementation	

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	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.	Includes Care Management File Review			Policies. **<u>File Review Results</u>** 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 3 of 3 applicable files. Ten (10) of 10 files had evidence of behavioral health care coordination. Ten (10) of 10 files met the requirement for referrals made when necessary. None (0) of the 10 behavioral health files were applicable towards the requirement for coordination of activities with the Chronic Care Management Program. Ten (10) of 10 behavioral health files met the requirement for referrals when necessary. Contact was made with the Integrated Medicaid Managed care Program Plan Care Manager for 9 of 9 applicable 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 Includes Care Management File Review		Full	This requirement is addressed in the Care Management Program Description Policy.	
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	Policy for care coordination Policy for PCP choice Member survey Detailed Workflows		Full	This requirement is addressed by the Continuity and Coordination of Services Policy and the member handbook.	

Core Benefits and Services						
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	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 monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by 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 Referrals to Specialty Health Care Services Policy and the Continuity and Coordination of Services Policy.	
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and					

Core Benefits and Services						
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	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 Health Risk Screening Policy. **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		Substantial	This requirement is addressed in the Continuity and Coordination of Services Policy. **File Review Results** Nine (9) 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. **Recommendation** The MCO should develop a review process to ensure that all members have a source of primary care and such care is documented in the case notes:	We are working toward retraining our staff to ensure all members have a current PCP and such is documented. We will work to have all training completed by the end of the 3rd quarter
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 in the Continuity and Coordination of Services 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	Policy for care coordination		Full	This requirement is addressed in the Continuity and Coordination of Services	

Core Benefits and Services						
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	providers;				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 Continuity and Coordination of Services 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 Continuity and Coordination of Services 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 Continuity and Coordination of Services Policy.	
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 provider manual and the Medical Record Review Policy.	
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 Continuity and Coordination of Services 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 Continued Stay and Discharge Planning Review Policy.	
6.30.2.11	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continued Stay and Discharge Planning Review Policy. **File Review Results** Six (6) of the 6 applicable case management files met this requirement. Six (6) of 6 applicable behavioral case management files met the discharge planning requirement.	

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
6.30.2.11.1.	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 and Medical Necessity 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 Includes Care Management File Review		Full	This requirement is addressed in the Post Discharge Member Outreach Work Process 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 in the Standards for Discharge Planning Policy.	
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 contacted by and is receiving services from aftercare providers as per the member's discharge plan.	Policy for care coordination Includes Care Management File Review		Full	This requirement is addressed by the Standards for Discharge Planning and Coordinated System of Care Policies.	
6.30.2.12	Document authorized referrals in its utilization management system;	Policy for care coordination		Full	This requirement is addressed in the Referrals to Specialty Health Care Services Policy.	

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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 Continuity and Coordination of Services 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 for care coordination Court proceedings		Full	This requirement is addressed in the judicial court liaison job description.	
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	Policy for care coordination		Full	This requirement is addressed in the Standards for Discharge Planning 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 Referrals to Specialty Health Care Services Policy and provider manual.	
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 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	Policy for BH care continuity		Full	This requirement is addressed in the Care Management Program Description Policy and the provider manual.	

Core Benefits and Services						
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	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 Referrals to Specialty Health Care Services 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 Emergency and Post-Stabilization Services Policy.	
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	Policy for BH care continuity		Full	This requirement is addressed in the Care Management Program Description Policy.	

Core Benefits and Services						
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	and primary care provider.					
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 Continuity and Coordination of Services Policy as well as the provider manual.	
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 Care Management Program Description 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 Care Management Workshops Handouts and the BH Screening Tool for Providers document.	
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; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders	Policy for BH care coordination		Full	This requirement is addressed in the provider manual and the Care Management Program Description Policy.	

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	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 PMPM Rate Exhibit Standard Final document and Acadiana Addiction Center LLC Contract.	
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 in the provider manual.	
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 the 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 Emergency Department Division Policy.	
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 Care Management Program Description 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 referral documents.	
6.36.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	Policy for provider initiatives		Full	This requirement is addressed in the provider manual and the document PMPM Rate Exhibit Standard Final.	
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 document BH Screening Tool for Providers.	

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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 document ICT Meeting Invite.	
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 DCFS Rounds documents.	
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 Care Management Program Description Policy.	
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 Care Management Program Description 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 Care Management Program Description and Care Plan Development and Implementation Policies.	
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 in the Care Management Program Description and Start Smart for Your Baby Overview Policies.	
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 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	Policy for CM Treatment plan template		Full	This requirement is addressed in the Care Management Program Description and Care Plan Development and Implementation Policies.	

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	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 Care Management Program Description Policies.	
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	Policy for CM		Full	This requirement is addressed in the Referrals to Specialty Health Care Services Policy and the provider manual.	
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 Care Management Program Description 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 Care Management Program Description 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 Policy for CM		Full	This requirement is addressed by the PQ039 case management reports provided and the Care Management Program Description Policy.	
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 PQ039 SHCN report.	
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 PQ039 SHCN report.	
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 PQ039 SHCN report.	
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 PQ039 SHCN report.	

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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 LHCC 2019 03 report.	
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 LHCC PASSR reports.	
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports		Full	This requirement is addressed by the PQ039 case management reports 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 by the PQ039 case management reports 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 in the Care Management Program Description Policy.	
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 in the Care Management Program Description Policy.	
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 in the Care Management Program Description Policy.	
6.42.4.1	Include the definition of the target population;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Care Management Program Description Policy and Nurtur Program Descriptions.	

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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
6.42.4.2	Include member identification strategies, i.e. through encounter data;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Care Management Program Description Policy and Nurtur Program Descriptions.	
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 in the Care Management Program Description Policy and Nurtur Program Descriptions.	
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 in the Care Management Program Description Policy and Nurtur Program Descriptions.	
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 in the Care Management Program Description and Predictive Modeling Policies.	
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 policies LA.CM.01 Care Management Program Description, LA.CM.04 Disease Specific Education Materials, and Nurtur Program Descriptions.	
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 Care Management Program Description Policy and Nurtur Program Descriptions.	
6.42.4.8	Address co-morbidities through a whole-person approach;	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Care Management Program Description 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 Care Management Program Description Policy.	
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 Care Management Program Description and Coordination with Envolve People Care DM Programs Policies.	
6.42.4.11	Include Program Evaluation requirements.	Policy for CCMP CCMP descriptions		Full	This requirement is addressed in the Care Management Program Description and Coordination with Envolve People Care DM Programs Policies.	

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	**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 in an email that the Reporting Unit from LDH sent (May 17, 2018, 4:41PM) to LHCCs regarding the retirement of the CCMP Report.	
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 an email that the Reporting Unit from LDH sent (May 17, 2018, 4:41PM) to LHCCs regarding the retirement of the CCMP 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 an email that the Reporting Unit from LDH sent (May 17, 2018, 4:41PM) to LHCCs regarding the retirement of the CCMP 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 an email that the Reporting Unit from LDH sent (May 17, 2018, 4:41PM) to LHCCs regarding the retirement of the CCMP 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 an email that the Reporting Unit from LDH sent (May 17, 2018, 4:41PM) to LHCCs regarding the retirement of the CCMP 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 Adequacy Policy on page 1 and in the Network Selection and Retention Policy.	
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 Network Selection and Retention Policy on page 1 and in the Provider Appointment Accessibility Standards Policy on page 1.	
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 Network Adequacy Policy on pages 4 to 14.	
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 Network Adequacy Policy on pages 14 to 16.	
7.1.7	The MCO's network providers shall ensure	Policy for Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
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	physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	Policy for Access and Availability			Provider Appointment Accessibility Standards Policy on page 1 and in the Network Adequacy Policy on pages 2 and 14.	
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 Provider Appointment Accessibility Standards Policy on page 3, in the Network Adequacy Policy on page 14, and in the provider manual on page 80.	
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 annually; • Assessing member satisfaction of the services	Network Provider Development and Management Plan Policy for Provider Network Provider manual/handbook Provider contracts		Full	This requirement is addressed in the Network Selection and Retention Policy on page 3, in the provider manual on pages 14 and 15, and in the Organizational Cultural Competency Policy. Upon request, the MCO submitted the Cultural Competency Report 2018 Q1 – 2019 Q2, which evidences tracking of provider training for cultural competency. The MCO also submitted the Culturally and Linguistically Appropriate Services (CLAS) Cultural Compliance Report for April–June 2018, which tracks the 3.5-hour training of new hires for crisis calls. Upon request, the MCO submitted the Annual CLAS Network Assessment Report dated October 2018, which analyzes membership and providers for language spoken and ethnicity as well as member grievances relating to discrimination and cultural competency. This report also provides a gap analysis and includes an action plan to overcome these gaps.	

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
	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 provider manual on page 34, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An	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 pages 34 and 35, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	

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
	appointment shall be arranged within forty-eight (48) hours of request;					
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 provider manual on page 35, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	
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 provider manual on page 35, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	
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 provider manual on page 35, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	
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 Member Handbook		Full	This requirement is addressed in the provider manual on page 35, in the Provider Appointment Accessibility Standards Policy on page 1 and in the member handbook on page 28.	
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	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 35, in the Provider Appointment Accessibility Standards Policy on page 2 and in the member handbook on page 28.	

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
	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;					
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 35, in the Provider Appointment Accessibility Standards Policy on page 2 and in the member handbook on page 28.	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	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 35, in the Provider Appointment Accessibility Standards Policy on page 2 and in the member handbook on page 28.	
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	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is addressed in the Network Adequacy Policy on pages 14 and 15 under Timely Access Exceptions. The medical provider and BH GeoAccess reports implement the maximum time/distance requirements. Access to some provider types in urban and rural areas do not meet the maximum time/distance The network analysis gap	We, LHCC will continue in our efforts at expanding our network consistently

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
	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.				report for 2019 Q1 evidences ongoing monitoring of existing gaps. The MCO has 100% of available Medicaid providers enrolled in most parishes and has ongoing efforts to attract additional providers. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	
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 Network Adequacy Policy on pages 4 and 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban parishes had access to all PCPs, adult PCPs, and pediatric PCPs statewide. Not all members in rural parishes had access to all PCPs and adult PCPs statewide. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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 Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements on pages 17 and 27. The MCO reports that it has 100% of available acute inpatient facilities under	We, LHCC will continue in our efforts at expanding our network consistently

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
					contract. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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 Network Adequacy Policy on pages 6, 7, 10 and 11. The medical provider GeoAccess reports implement the maximum time/distance requirements. All members had access to most specialists within 90 miles, except for access to endocrinologists, to whom only 88.9% of members had access within 90 miles. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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 Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban and rural parishes had access to radiology services within 20 and 30 miles, however rates were 99.5% urban and 94.5% rural.	We, LHCC will continue in our efforts at expanding our network consistently

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
					Not all members in had access to lab services within the required limits however rates were 99.5 urban and 99.9 rural. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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 Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban and rural parishes had access to pharmacies within 10 and 30 miles, respectively. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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 Network Adequacy Policy on page 5. The medical provider GeoAccess reports implement the maximum time/distance requirements. Not all members in urban and rural parishes had access to hemodialysis center within 10 and 30 miles, respectively. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently

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
7.3.7 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 Network Adequacy Policy on pages 7 to 10. The behavioral health GeoAccess reports implement this requirement. Over 95% of members in rural parishes had access to BH specialists and psychiatrists within 30 miles or 60 minutes. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	
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 Network Adequacy Policy on pages 7 to 10. The behavioral health GeoAccess reports implement this requirement. Over 90% of members in urban parishes had access to BH specialists and psychiatrists within 15 miles or 30 minutes. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	
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 admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan Policy for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the Network Adequacy Policy on pages 9, 10 and 12. The behavioral health GeoAccess reports implement the maximum time/distance 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	Network Provider Development and Management Plan		Substantial	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports	We, LHCC will continue in our efforts at expanding our network consistently

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
	shall not exceed 10 business days.	Policy for Access and Availability GeoAccess reports Requests for exceptions			implement this requirement. Fewer than 80% of adult members in urban and rural parishes had access to ASAM Level 3.3 within 30 miles or 60 minutes. The MCO states that ASAM access is an issue throughout the state. Not all facilities accept Medicaid. The MCO monitors the networks of other MCOs in the state to see if there are any not yet in the MCO network so it can attempt to enroll these facilities. They also enter into single case agreements where possible. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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		Substantial	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports implement this requirement. Over 90% of adult members in urban parishes had access to ASAM Level 3.5 within 30 miles or 60 minutes; however, fewer than 60% of adult members in rural parishes had access to these services within these parameters. Over 90% of pediatric members had access to these services within 60 miles or 90 minutes. **Recommendation** The MCO should continue its efforts to	We, LHCC will continue in our efforts at expanding our network consistently

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
					expand its provider network to meet the time and distance 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		Full	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports implement this requirement. Almost 90% of adult member sin urban and rural parishes had access to ASAM Level 3.7 services within 60 miles or 90 minutes. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance 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		Full	This requirement is addressed in the Network Adequacy Policy on pages 9 and 12. The behavioral health GeoAccess reports implement this requirement. Over 90% of adults members in urban and rural parishes had access to ASAm Level 3.7WM services within 60 miles or 90 minutes.	
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		Full	This requirement is addressed in the Network Adequacy Policy on pages 9, 10 and 12. The behavioral health GeoAccess reports implement this requirement. All adolescent members had access to PRTFs within 200 miles or 210 minutes.	
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in	Network Provider Development and Management Plan		Full	This requirement is addressed in the Network Adequacy Policy on page 11.	

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
	writing to LDH for approval.	Policy for Access and Availability GeoAccess reports Requests for exceptions				
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 Network Adequacy Policy on page 11.	
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 Network Adequacy Policy on page 15. The network adequacy review for 2018 Q4 evidences the implementation of this requirement. The ratios tab uses the ratios indicated for each type of provider in the Provider Network Companion Guide. The MCO's ratios exceed the required ratios for all provider types.	
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 Provider Appointment Accessibility Standards Policy, the Evaluation of the Accessibility of Services policy on pages 1 to 5, the provider handbook on pages 34 to 37, the member handbook on page 28, and in the Network Adequacy Policy on pages 11 and 12. The MCO provided secret shopper call logs for the review period. The MCO also provided mitigation plans. This is also found on the member website.	
7.5.2 7.5.2.1	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess	GeoAccess reports Communication to LDH/		Full	This requirement is addressed in the Network Adequacy Policy on page 15. The	

Provider Network Requirements						
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7.5.2.2 7.5.2.3	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 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.	attestation			MCO submitted 2019 Q1 GeoAccess reports and attestation to evidence the implementation of this requirement.	
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 Network Adequacy Policy on pages 12 and 15.	
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);	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the Network Selection and Retention Policy on pages 4 to 7 The MCO submitted the participating provider agreement template to evidence 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
	• Rural Health Clinics (RHCs) (free-standing and hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the 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).		-			

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
7.6.1.7	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 Network Selection and Retention Policy on pages 3 and 4.	
7.6.1.8	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Provider Development and Management Plan Policy for Provider Network		Full	This requirement is addressed in the Network Selection and Retention Policy on page 18.	
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 Network Selection and Retention Policy on pages 9 and 18 and in the Network Development and Management Plan on page 5.	
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 Network Selection and Retention Policy on page 18.	
7.6.1.11	The MCO shall work with LDH and other MCOs to	Policy for care coordination		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
	convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Meeting/Forum Meetings			Network Selection and Retention Policy on page 9. The MCO submitted an email about My Choice Louisiana Transition Coordinator Training from LDH.	
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					
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 Network Selection and Retention Policy on page 6.	
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	Policy for Provider Network		Full	This requirement is addressed in the Network Selection and Retention Policy on page 6. This requirement is also included in the Practitioner Credentialing & Recredentialing Policy on page 54; however this was added after the review period (as per the revision log on page 48.)	

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
	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 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		Full	This requirement is addressed in the Network Selection and Retention Policy on page 6. This requirement is also included in the Practitioner Credentialing & Recredentialing Policy on page 54; however this language was added to the policy after the review period (as per the change log on page 48.)	
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 Network Selection and Retention Policy on page 2 and in the Nondiscriminatory Credentialing and Recredentialing Policy on page 1.	
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		Full	This requirement is addressed in the Network Adequacy 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
		Provider manual/handbook Policy for Provider Credentialing				
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 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.	Policy for Provider Network Policy for Provider Termination Sample notice to providers Sample notice to LDH		Full	This requirement is addressed in the Provider Termination Policy on page 2. The MCO provided two sample termination letters to providers dated September 12, 2018 and March 7, 2019 that informs the providers of termination "effectively immediately." The letters were sent via certified mail. Upon request, the MCO provided proof of electronic communications with LDH that meet the timeliness requirement and evidence that the notices were mailed in a timely manner.	
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 Network Adequacy Policy on page 15. This requirement is also addressed in the Provider Termination Policy on page 3; The sample notification letter to a member, dated March 29, 2019, about PCP termination evidences the implementation of this requirement.	
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 member handbook on page 26 and in the Notice to Members of Provider Termination Policy on page 1. This requirement is also addressed in the Provider Termination Policy on page 3. The MCO provided examples of letters sent to members whose providers had terminated from the network.	
7.7	**Mainstreaming**					

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
7.7.1	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		Full	This requirement is addressed in the provider manual on page 44.	
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 addressed in the provider manual on page 44; however, cognitive disability is not included in this language. **Recommendation** The MCO should add "cognitive" to the language addressing this requirement in their policies.	Marketing has added this language to Provider Manual and will submit to LDH for approval by 09/27/2019.
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts Provider Handbook/Manual		Full	This requirement is addressed in the provider manual on page 44.	
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		Full	This requirement is addressed in the provider manual on page 44.	
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		Full	This requirement is addressed in the provider manual on page 44.	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify LDH in writing	Policy for provider contracts Provider Contract Provider Handbook		Full	This requirement is addressed in the provider manual on page 44.	
7.7.4	The MCO shall ensure that providers do not	Policy for provider		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
	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.	contracts Provider Contract Provider Handbook			provider manual on page 44.	
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 page 48.	
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 page 48.	
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 page 48.	
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 page 48.	
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	Policy for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual on page 48.	
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 page 48.	
7.8.2.7	Ensuring that in the process of coordinating care,	Policy for PCP		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
	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.	Responsibilities Provider Handbook/Manual Provider contracts			provider manual on page 49.	
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 49.	
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 49.	
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 49.	
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 49.	
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 49.	
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	Policy for Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
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	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 Access to Specialty Providers GeoAccess reports			Network Adequacy Policy on page 2. The network adequacy review 2018 Q4 submitted by the MCO evidences the inclusion of pediatric specialists in the provider network.	
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 Network Adequacy Policy on page 12, where perinatal visit access requirements for 1st, 2nd, and 3rd trimester of pregnancy and high-risk pregnancy are detailed. Page 13 of the same policy details level III neonatal ICU access.	
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		Full	This requirement is addressed in the Network Adequacy Policy on page 1. The GeoAccess reports for submitted by the MCO evidences the implementation of this requirement.	
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	Policy for Provider Network Policy for Access to Specialty Providers		Full	This requirement is addressed in the Network Adequacy Policy on page 11.	

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
	does not meet the access standards specified in the Contract.					
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 Network Adequacy Policy on page 2.	
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: .3 One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. .4 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.	Policy for Provider Network GeoAccess reports		Substantial	This requirement is addressed in the Network Adequacy Policy on pages 12 and 13. The GeoAccess reports evidence the implementation of this requirement. As reported above there are minor coverage gaps across the provider network. **Recommendation** The MCO should continue its efforts to expand its provider network to meet the time and distance requirements.	We, LHCC will continue in our efforts at expanding our network consistently
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 Network Adequacy Policy on page 13.	
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	Policy for Provider Network GeoAccess reports		Full	This requirement is addressed in the Network Adequacy Policy on page 13. The GeoAccess reports evidence 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
	contract with out-of-state hospitals to comply with these requirements.				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 arrangements with out-of-network providers.	Policy for use of out-of-network providers Policy for providing access to tertiary care GeoAccess reports		Full	This requirement is addressed in the Network Adequacy Policy on page 13. The provider manual also addressed tertiary care on page 77. All available providers under contract. The MCO is aware that there still access issues. The MCO has negotiated with providers such as home health 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 Network Adequacy Policy on pages 13 and 14.	
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 Network Adequacy. The GeoAccess reports evidence that the MCO's network has providers that can offer family planning services to members.	
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	Policy for direct access services Member Handbook		Full	This requirement is addressed in the Network Adequacy Policy on pages 13 and 14 and in the member handbook on page 23.	

Provider Network Requirements						
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	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.					
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 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.	Policy for direct access services Member Handbook		Full	This requirement is addressed in the member handbook on page 16, in the provider handbook on page 60, and in the Network Development and Management Plan on page 10.	
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 provider handbook on page 161, and in the Network Development and Management Plan on page 10.	
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	Policy for Prenatal Care Services Access Policy for Assignment of PCPs including Auto Assignment		Substantial	This requirement is addressed in the member handbook on pages 34 and 35; however, the time requirement is not included. **Recommendation** The MCO should add the time frame for	We will ensure our Member's Handbook is updated to add the time frame for selection and will be sent to LDH for approval by 09/13/2019. Once approved, we will post the

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	shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.				selection to the member handbook.	new version of the handbook on the website and begin production on hard copies.
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 Network Adequacy Policy on page 13 and in the provider manual on pages 27 to 30. The GeoAccess reports submitted by the MCO evidence the availability of services such as radiology and laboratories.	
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	Policy for Provider Network Contracts with FQHC/RHCs		Full	This requirement is addressed in the Network Selection and Retention Policy on page 4. The MCO submitted a contract with an FQHC (Access Health Louisiana) to evidence the implementation of this requirement.	
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 Network Selection and Retention Policy on page 4.	
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 Network Selection and Retention Policy on pages 4 and 5. The MCO evidenced the implementation of this requirement with the contract with OPH.	
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	Policy for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the Network Selection and Retention Policy on pages 4 and 5. The MCO evidenced the implementation of this requirement with the	

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	(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.				contract with OPH.	
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 Network Selection and Retention Policy on page 8. The implementation of this requirement is evidenced by the GeoAccess reports submitted by the MCO.	
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 Network Selection and Retention Policy on page 8	
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-			Full	This requirement is addressed in the Network Selection and Retention Policy on page 8.	

Provider Network Requirements						
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	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.					
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 Network Selection and Retention Policy on page 8	
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC 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.	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the Network Selection and Retention Policy on page 8.	
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 Network Selection and Retention Policy on page 9. The provider directory for members lists BH services that are open for 24 hours as well as those with limited hours on Fridays and closed on the weekends. The GeoAccess reports evidence the monitoring of access to prescribers.	
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-	Policy for provider network Policy for care coordination Network reports		Full	This requirement is addressed in the Network Selection and Retention Policy. The member handbook lists the crisis services and the 24-hour crisis hotline on	

Provider Network Requirements						
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	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 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.				pages 4, 18 to 19, and 44. Transportation information is included in the member handbook on pages 4 and 13. The Behavioral Health Providers by Level of Care Report for 2019 Q1 includes crisis intervention providers.	
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 Network Selection and Retention Policy on page 10 and in the provider manual on page 135.	
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 Network Selection and Retention Policy on page 10. The network analysis gap report for 2019 Q1 submitted by the MCO evidences ongoing gap analysis and details efforts to reduce gaps.	

Provider Network Requirements						
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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		Full	This requirement is addressed in the Network Selection and Retention Policy on page 10.	
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 Network Selection and Retention Policy on page 7.	
7.8.15.2 7.8.15.2.1 7.8.15.2.2 7.8.15.2.3	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services 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 Network Selection and Retention Policy on page 7.	
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			Full	This requirement is addressed in the Network Selection and Retention Policy on page 7.	

Provider Network Requirements						
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	otherwise eligible to receive such services.					
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 Network Selection and Retention Policy on page 7.	
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 Network Selection and Retention Policy on page 7.	
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 Network Development and Management Policy on page 1.	
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Policy on page 1.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care	Provider Network Development and		Full	This requirement is addressed in the Network Development and Management	

Provider Network Requirements						
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	needs of the members in the MCO;	Management Plan			Policy on page 1.	
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 Network Development and Management Policy on page 1.	
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 Network Development and Management Policy on page 1.	
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 Network Development and Management Policy on page 1.	
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 addressed in the Network Development and Management Policy on page 1.	
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 Network Development and Management Plan on pages 6 to 12.	
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 Network Development and Management Plan on pages 6 to 8. The GeoAccess reports for medical providers, BH providers and vision submitted by the MCO evidence the monitoring of the adequacy of these services.	
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on page 6.	
7.9.2.4	Access to Specialists	Provider Network Development and		Full	This requirement is addressed in the Network Development and Management	

Provider Network Requirements						
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		Management Plan			Plan on pages 6 and 7.	
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on pages 9 and 10.	
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on pages 23 to 27.	
7.9.2.7	Timely Access	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on page 23.	
7.9.2.8	Service Area	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on pages 9 and 23.	
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health , • Special Conditions for Prenatal Providers, • Second Opinion • Out-of-Network Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development and Management Plan on pages 10 and 11.	
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 Network Development and Management Plan on pages 11 and 12.	
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 Network Development and Management Plan on page 13.	

Provider Network Requirements						
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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 Network Development and Management Plan on page 13.	
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 Network Development and Management Plan on page 11. The GeoAccess reports submitted by the MCO evidence the implementation of this requirement.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Policy for Network Development and Management		Full	This requirement is addressed in the Network Development and Management Policy on page 2.	
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 Network Development and Management Policy on page 5.	
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 Network Development and Management Policy on page 5.	
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 Network Development and Management Policy on page 5.	
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 Network Development and Management Policy on page 5.	
7.9.5.6	Process expedited and temporary credentials.	Policy for Network		Full	This requirement is addressed in the	

Provider Network Requirements						
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	Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Development and Management			Network Development and Management Plan on page 5. This requirement is also addressed in the Practitioner Credentialing & Recredentialing Policy on page 54 and in the Nondiscriminatory Credentialing and Recredentialing Policy on page 1.	
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 Network Development and Management Plan on page 5 and in the Provider Orientations & Ongoing Training Policy on pages 1 and 2.	
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 Network Development and Management Plan on page 5 and in the Provider Complaints Policy on page 1.	
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 1.	
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 Network Development & Management Policy on page 1.	
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 Network Development & Management Policy on page 1.	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the Network Development & Management Policy on page 1. The Network Development and	

Provider Network Requirements						
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	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.				Management Plan includes the specialized behavioral health network information on pages 17 to 28.	
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 Network Development & Management Policy on page 1. The Network Development and Management Plan includes the specialized behavioral health network information on pages 23 to 27.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the Network Development & Management Policy on page 2 and in the Network Development and Management Plan on page 15. The Network Development and Management Plan includes this information on pages 13 and 14.	
	• 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 Network Development & Management Policy on page 2 and the Network Development and Management Plan on page 15.	
	• 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	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the Network Development & Management Policy on page 2. The Network Development and Management Plan addresses this requirement on pages 15. The MCO's GeoAccess reports for BH providers and specialists evidence ongoing mapping and	

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
	request;				quarterly reporting.	
	• 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 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.	Policy for network Needs assessment findings		Full	This requirement is addressed in the Network Development & Management Policy on pages 2 and 3. The Network Development and Management Plan addresses this requirement on page 15.	
	• 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;	Network development Implementation plan Policy for provider network		Full	This requirement is addressed in the Network Development and Management Policy on page 3. The Network Development and Management Plan includes this information as attachments (BH GeoAccess report, BH network adequacy report, etc.)	

Provider Network Requirements						
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	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.					
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 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.	Evidence of submission of network development Plan to LDH Network and development plan		Full	This requirement is addressed in the Network Development and Management Policy on page 3 and in the Network Development and Management Plan on page 15. The Network Development and Management Plan includes this information on pages 17 to 28 and as attachment reports on page 23.	
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	Network development and management plan		Full	This requirement is addressed in the Network Development and Management Policy on page 4 and in the Network Development and Management Plan on pages 13 and 14. The Network Development and Management Plan includes this	

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
	health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.				requirement on pages 23 to 28.	
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-	Network development and management plan		Full	This requirement is addressed in the Network Development and Management Policy on page 4 in the Network Development and Management Plan on pages 13 and 14. The Network Development and Management Plan includes this requirement on pages 23 to 28.	

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 options to serve the needs of youth in the state.					
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, 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.;	Network development and management plan		Full	This requirement is addressed in the Network Development and Management Policy on pages 4 and 5, and in the Evaluation of Practitioner Availability Policy on pages 1 and 2. The Network Development and Management Plan addressed this requirement on page 16.	

Provider Network Requirements						
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	• 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 specialized behavioral healthcare.	Network development and management plan		Full	This requirement is addressed in the Network Development and Management Policy on page 5 and in the Network Development and Management plan on pages 11 and 12. The Network Development and Management Plan includes this requirement on page 12 and pages 23 to 27.	
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%);	Evidence of communications with LDH Policy for provider contracting		Full	This requirement is addressed in the Network Selection and Retention Policy on pages 12 and 13.	

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
	• 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.					
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 eligibility of a new population.	Evidence of communication with LDH Policy for Provider network		Full	This requirement is addressed in the Network Selection and Retention Policy on pages 11 and 12.	
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 Network Selection and Retention Policy on pages 11 and 12. The MCO submitted a sample member notification of PCP termination dated March 29, 2019, which evidences the implementation of this requirement.	
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 Network Selection and Retention Policy on page 12.	
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	Notification to LDH Policy for provider network		Full	This requirement is addressed in the Network Selection and Retention Policy on	

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 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.				page 12.	
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Provider contracts Policy for provider contracting		Full	This requirement is addressed in the Termination Policy on page 2. Sample contracts with clinics submitted by the MCO evidence the implementation of this requirement.	
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	Evidence of notifications Policy for provider network		Full	This requirement is addressed in the Network Selection and Retention Policy on page 13.	

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
	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.					
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 Network Selection and Retention Policy on page 13.	
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 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	Request for approval letter		Full	This requirement is addressed in the Network Selection and Retention Policy on pages 13 and 14.	

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 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 in the Network Selection and Retention Policy on page 14.	
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		Full	This requirement is addressed in the Network Selection and Retention Policy on page 14.	
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 Network Selection and Retention Policy on page 17.	
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	Policy for Network Management Policy for Provider		Full	This requirement is addressed in the Network Selection and Retention 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
	populations or specialize in conditions that require costly treatment.	Selection and Retention				
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 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.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on pages 1, 44 and 53.	
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	Policy for provider contracting		Full	This requirement is addressed in the Organizational Assessment and Reassessment Policy on pages 9 and 28.	

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
	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).					
7.14.2	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		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on pages 6 and 52. 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	

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
					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 Credentialing and Recredentialing Policy on page 1.	
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 Credentialing and Recredentialing Policy on page 1.	
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 Credentialing and Recredentialing Policy on page 53. **Credentialing File Review Results** Five (5) of five (5) credentialing applications were processed within 60 days.	
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 Credentialing and Recredentialing Policy on page 53.	
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 Credentialing and Recredentialing Policy on page 53. The MCO submitted the electronic version of the provider directory to evidence the implementation of this requirement.	
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 Credentialing and	

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
					Recredentialing Policy on page 53.	
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 Oversight of Delegated Credentialing Policy on pages 1 and 18.	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Oversight of Delegated Credentialing Policy on page 18.	
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 Oversight of Delegated Credentialing Policy on page 18.	
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		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on pages 30 and 52.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 4. **<u>Recredentialing File Review Results</u>** Five (5) of five (5) files were completed for recredentialing within three years.	
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	Policy for credentialing & recredentialing		Full	This requirement is addressed in the Practitioner Credentialing and Recredentialing Policy on page 10 and evidenced by the Practitioner Disciplinary	

Provider Network Requirements						
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	and procedures should include but are not limited to the encouragement of applicable board certification.				Action and Reporting Policy, Ongoing Monitoring of Sanctions and Complaints Policy and the Practitioner Appeal Hearing Process Policy.	
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 Practitioner Disciplinary Action and Reporting Policy on pages 6 and 20.	
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		Full	This requirement is addressed by the Practitioner Appeal Hearing Process Policy.	
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	Policy for Communication of Anti-gag Clause Provider Handbook/Manual		Full	This requirement is addressed in the provider handbook on page 49 under Provider Rights. The sample provider	

Provider Network Requirements						
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	within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	Provider contracts			contract submitted by the MCO also includes this requirement on page 25.	
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 sample provider contract submitted by the MCO on page 25.	
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 sample provider contract submitted by the MCO on page 25.	
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 sample provider contract submitted by the MCO on page 25.	
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 sample provider contract submitted by the MCO on page 25.	
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		Full	This requirement is addressed in the Network Development and Management Plan on page 5 and in the member handbook on page 57.	

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.	P/P for UM Evidence of timely submission of P/P for UM		Full	This requirement is addressed in the MCO UM Program Description document and LDH Policy Tracker document.	
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;	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
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;	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.2.3	Are considerate of the needs of the members; and	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
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;	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	P/P for UM		Full	This requirement is addressed in the UM Documentation in TruCare Notes.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	P/P for UM		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
8.1.3.5	Mechanisms to ensure consistent application of	P/P for UM		Full	This requirement is addressed in the	

Utilization Management						
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	review criteria and compatible decisions;				Utilization Management Program Description Policy.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	P/P for UM		Full	This requirement is addressed in the UM Program Description Document and MMC Committee Slides provided after the review.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	P/P for UM		Full	This requirement is addressed in the Utilization Management Program Description Policy.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	P/P for UM P/P Coordination of services		Full	This requirement is addressed on pages 8 and 25 of the Utilization Management Program Description and page 1 of the Clinical Decision Criteria and Application Policy.	
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;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the Coordinated System of Care Policy and DCFS Rounds Agenda provided after the review.	
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;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the Continued Stay and Discharge Planning Review Policy.	
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	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the Court Ordered Services Policy.	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of	P/P for UM P/P Coordination of		Full	This requirement is addressed in the Care Management Program Description Policy.	

Utilization Management						
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	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.	services				
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.	P/P for UM P/P for guideline development coordination P/P for guideline research, selection, adoption, review, update, & update schedule Sample adopted guidelines		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	P/P for UM P/P for guideline dissemination Sample adopted guidelines		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	Provider contracts Compliance reports		Full	The requirement is addressed in the Behavioral Health Provider Quality Policy.	
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:	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	P/P for UMP/P for medical management criteria		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
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;	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	

Utilization Management						
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8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
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.	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the Appropriate UM Professionals Policy.	
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.	P/P for UM P/P for guideline dissemination		Full	This requirement is addressed on the MCO website as well as in the policies provided.	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	P/P for UM P/P for required information P/P for additional information		Full	This requirement is addressed in the Clinical Information and Documentation Policy.	
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	P/P for UM		Full	This requirement is addressed in the Clinical Information and Documentation Policy.	

Utilization Management						
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	release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.					
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.	P/P for UM Staffing plan		Full	This requirement is addressed in the Appropriate UM Professionals Policy and organizational chart provided after the review.	
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.	P/P for UM		Full	This requirement is addressed in the Clinical Decision Criteria and Application Policy.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	P/P for UM Staffing plan		Full	This requirement is addressed in the Appropriate UM Professionals Policy and organizational chart provided after the review.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	P/P for UM		Full	This requirement is addressed in the Appropriate UM Professionals Policy.	
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.	P/P for UM Includes UM File Review		Full	This requirement is addressed in the Appropriate UM Professionals Policy. **File review results** Eight (8) out of ten (10) Utilization Management files reviewed were reviewed by a licensed clinical professional. Two (2) out of ten (10) Utilization Management files reviewed were not applicable, as they were administrative denials.	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or	P/P for UM		Full	This requirement is addressed on page 1 of the Appropriate UM Professionals Policy.	

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	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.					
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.	P/P for UM		Full	This requirement is addressed in the Appropriate UM Professionals Policy.	
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.	P/P for UM		Full	This requirement is addressed in the Covered Benefits and Services Policy.	
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.	P/P for UM		Full	This requirement is addressed in the Utilization Management Program Description Policy.	

Utilization Management						
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8.4	**Service Authorization**					
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	P/P for UM P/P for service authorization		Full	This requirement is addressed in the Utilization Management Program Description Policy.	
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:	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description, Covered Benefits and Services Policy, and Timeliness of UM Decisions Policy.	
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;	P/P for UM P/P for service authorization		Full	The requirement is addressed in the Timeliness of UM Decisions and Notifications Policy and the Authorizations – Medical Pharmacy Behavioral Health Policy.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the Utilization Management Program Description.	
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;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the Appropriate UM Professionals Policy.	
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;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the Utilization Management Program Description.	
8.4.2.5	The MCO's service authorization system shall	P/P for UM		Full	This requirement is addressed in the TruCare	

Utilization Management						
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	provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	P/P for service authorization			Standards for Documentation Policy.	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	P/P for UM P/P for service authorization		Full	This requirement is addressed in the TruCare Standards for Documentation Policy. The MCO explained their authorization process within TruCare.	
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.	P/P for UM P/P for service authorization		Full	This requirement is addressed in the Utilization Review Policy.	
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.	P/P prior authorization P/P for UM		Full	The requirement is addressed in the Observation and Observation to Inpatient Work Process Document and Common Observation Policy.	
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.	P/P prior authorization P/P for UM		Full	This requirement is addressed in the Utilization Management Program Description.	
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].	P/P for UM		Full	This requirement is addressed in the Appropriate UM Professionals Policy.	

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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.	P/P for UM		Non-compliance	This requirement is not addressed - the MCO states they do not have a policy regarding this element as they consider this a reporting element. Additionally, the documentation provided after the review did not contain this requirement. **Recommendation** The MCO should ensure that this requirement is included in their policies regarding concurrent utilization reviews.	We will update LA.UM.01 to include RFP verbiage regarding concurrent utilization reviews as requested by IPRO and bring through the next policy committee meeting on 9/24/2019 for approval.
8.4.5.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric	P/P for UM Evidence of timely submissions Notification communication to member/provider		Non-compliance	This requirement is not addressed in any of the policies or documents provided by the MCO – all of the policies provided were in regards to procedures for a crisis call center. **Recommendation** The MCO should ensure that this requirement is included in their policies regarding provision of Emergency Inpatient Hospital Psychiatric Screen and concurrent utilization review.	We will update LA.UM.01 to include RFP verbiage regarding provision of Emergency Inpatient Hospital Psychiatric Screen and concurrent utilization review as requested by IPRO and bring through the next policy committee meeting on 9/24/2019 for approval.

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

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	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.	P/P Service utilization P/P Certification/recertification		Full	This requirement is addressed in the Psychiatric Treatment Facility Policy and Behavioral Health Organizational Chart that was provided after the review.	
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 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).	P/P for UM LMHP Subcontract		Full	This requirement is addressed in the Psychiatric Treatment Facility Policy.	
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.	P/P certification		Full	This requirement is addressed in the Psychiatric Treatment Facility Policy.	
8.4.6.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's	P/P certification Tracking report		Full	This requirement is addressed in the Psychiatric Treatment Facility Policy.	

Utilization Management						
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	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 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	P/P for UM Hospital reports				

Utilization Management						
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	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.	P/P for UM P/P for standard service authorization		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy and Service Authorization Report that was provided after the review.	
8.5.1.1.1 8.5.1.1.1.1 8.5.1.1.1.2	The service authorization decision may be extended up to fourteen (14) additional calendar days if: • The member, or the provider, requests the			Full	This requirement is addressed in the Timeliness UM Decisions and Notifications 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
	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.	P/P for UM P/P for concurrent review determinations		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
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.	P/P for UM P/P for expedited service authorization		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
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.	P/P for UM P/P for post authorization		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
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.	P/P for UM P/P for post authorization		Full	This requirement is addressed in the Retrospective Review for Services Requiring Authorizations Policy.	
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or	P/P for UM P/P for post authorization		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications	

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
	reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.				Policy.	
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.	P/P for UM P/P for notice timing		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy. **Recommendation** The MCO should ensure that all provider notification requirements are executed within the appropriate timeframes. **Final Review Determination** The review determination was changed to Full. Based on the response provided by LHCC, we confirmed that approvals were not reviewed in the file review.	This element is in regards to approval notifications. We did not supply approval authorizations within our file review. However, We will provide education and training to our staff by 9/30/2019 to ensure that all provider notification requirements are executed within the appropriate timeframes.
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.	P/P for UM P/P for notice timing		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
8.5..4.1.2	**Adverse [Notice of Action]**					
8.5.4.1.2.1	The MCO shall notify the member, in writing using	P/P for UM		Full	This requirement is addressed in the Adverse	

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
	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.	P/P for notice timing Includes UM File Review			Determination Notices policy and Appeal Denial Letter and Adverse Determination Denials Notice Policy. **File review results** Eight (8) out of ten (10) Utilization Management files reviewed met the member notification requirements. Two (2) out of ten (10) Utilization Management files were administrative denials, which do not allow for appeal, which would make these files not applicable. Eight (8) out of eight (8) Utilization management files reviewed which contained member notification letters met the requirements.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision 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.	P/P for UM P/P for notice timing Includes UM File Review		Substantial	This requirement is addressed in the Adverse Determination Notices Policy and demonstrated in the administrative provider denial letter example. **File review results** Eight (8) out of ten (10) Utilization Management files reviewed met the provider notification requirements. Two (2) out of ten (10) Utilization Management files reviewed did not meet provider notification requirements. One (1) file reviewed contained no notifications, and in one (1) file, the provider was verbally notified in two (2) business days, which exceeds the requirement. **Recommendation** The MCO should ensure that all provider notification requirements are executed within the appropriate timeframes.	We will provide education and training to our staff to ensure that all provider notification requirements are executed within the appropriate timeframes, all training will be completed by 09/30/2019.

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
8.5.4.1.3	**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.	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy and within the member handbook. **File Review Results** Five (5) out of five (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)].	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	P/P for UM P/P for informal reconsideration P/P for notice timing Includes Informal Consideration File Review		Substantial	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy. **File Review Results** Four (4) out of five (5) Informal Reconsideration files reviewed met the one (1) day requirement. One (1) file reviewed was outside the one (1) day requirement. **Recommendation** The MCO should ensure that all informal reconsideration requirements are executed within the appropriate timeframes.	We will provide education and training to our staff to ensure that all informal reconsideration requirements are executed within the appropriate timeframes completed by 9/30/19.
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for	P/P for UM P/P for informal		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications	

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
	a Notice of Appeal Resolution.	reconsideration P/P for notice timing			Policy.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Emergency and Post-Stabilization Services Policy.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Covered Benefits and Services Policy.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Covered Benefits and Services Policy.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Continuity and Coordination of Services Policy.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Continuity and Coordination of Services Policy.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Referrals to Specialty Health Care Services Policy.	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Covered Benefits and Services Policy.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Covered Benefits and Services 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
8.5.4.2	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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Covered Benefits and Services Policy.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Timelines of UM Decisions and Notifications Policy.	
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.	P/P for UM		Full	This requirement is addressed in the Clinical Information and Documentation Policy.	
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.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the Timeliness of UM Decisions and Notifications Policy.	
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.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the provider contract.	
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.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the provider contract.	
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 Potential Quality of Care Incidents Policy.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	P/P for UM		Full	This requirement is addressed in the Potential Quality of Care Incidents 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 Court Ordered Services Policy.	

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 Disenrollment 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; • The member's active specialized behavioral health provider ceases to contract with the	Policy for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy on pages 1 and 2.	

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**
	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.					
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		Full	This requirement is addressed in the Disenrollment Policy on page 2.	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Policy for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy on page 3.	
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		Full	This requirement is addressed in the Disenrollment Policy on page 3. The members are informed of the option to appeal to the state fair hearing process in the member handbook on page 61.	
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	Policy for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment Policy on page 3. The disenrollment notification letter template also meets this requirement.	

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
	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)).					
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 reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.	Policy for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy on page 3.	
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 Disenrollment Policy on page 3.	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	Policy for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment Policy on page 3. The disenrollment notification letter template includes allowed reasons for involuntary disenrollment and the effective date of disenrollment.	
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		Full	This requirement is addressed in the Disenrollment Policy on pages 3 and 4.	

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		Full	This requirement is addressed in the Disenrollment Policy on page 4.	
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 Disenrollment Policy on page 4.	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the 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		Full	This requirement is addressed in the Disenrollment Policy on page 4.	

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	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.	Policy for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Written materials Guidelines Policy on page 1. The sample written letter to a member provided by the MCO evidences the implementation of this requirement.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written materials Guidelines Policy on page 1. The font size of the member handbook was tested using Adobe and found to be 11.4, which meets this requirement.	
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.	Policy for Written Member Materials Guidelines Policy for Disclosure of Financial Interest		Full	This requirement is addressed in the Written materials Guidelines Policy on page 1.	
12.9.5	All written materials must be in accordance with	Policy for Written Member		Full	This requirement is addressed in the Written	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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 LDH "Person First" Policy, Appendix NN.	Materials Guidelines Policy for Compliance with "Person First" Policy Sample written member materials including Member Handbook			materials Guidelines Policy on page 1. The member handbook explains benefits for members with chronic care management needs on page 39. The MCO also provided a flyer about sickle cell disease for members with this condition or caring for a loved one with this condition.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written materials Guidelines Policy on page 2. The member materials, including the member handbook, provided by the MCO meet 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.	Policy for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Written materials Guidelines Policy on page 2. The member handbook has all the required information on the back cover.	
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	Policy for Written Member Materials Guidelines Policy for Informing Members/ Potential Members of Interpretation Services		Full	This requirement is addressed in the Written materials Guidelines Policy on page 2. The member handbook informs the members of this requirement in full in English and in Spanish on page 31.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written materials Guidelines Policy on page 2. The member handbook includes this information under "How to Get Care" on page 24.	
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.	Policy for Written Member Materials Guidelines Policy for Informing Members/ Potential Members of Access to Alternative Forms of Communication		Full	This requirement is addressed in the Written materials Guidelines Policy on page 2. The member handbook informs members of their right to receive all written information at no cost, in other languages, for special needs, including oral interpretation on pages 57 and 58. The handbook also includes these requirements in the non-discrimination policy on page 85.	

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan 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**
12.9.15	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.	Policy for Member Education Policy for Member Disenrollment Policy for Member Enrollment Policy for Member Re-enrollment		Full	This requirement is addressed in the Member Education Requirements Policy on page 1. This policy includes new member materials and current member materials. The disenrollment policies also comply with this requirement.	
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 informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal		Full	This requirement is addressed in the Member Education Requirements Policy on page 4. The MCO's member website, portal, apps and Facebook page meet this requirement.	
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		Full	This requirement is addressed in the Member Education Requirements Policy on page 4. The MCO provided two newsletters for 2019 and there are four newsletters archived on the MCO website for previous years, evidencing that the MCO is meeting and exceeding this requirement.	
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	Brochures and other examples of literature including EPSTD materials		Full	This requirement is addressed in the Member Education Requirements Policy on page 4. The MCO provided information literature for	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	outreach materials and member appointment and preventive testing reminders;				members covering subjects such as well child visits, ER, new baby/perinatal care, chronic diseases, preventive testing and appointment reminders. The welcome packet also includes well-child check-up information and pregnancy form. The member handbook includes the well-child check-up information on page 14.	
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		Full	This requirement is addressed in the Member Education Requirements Policy on page 4. The MCO provided many brochures and pamphlets, including for pregnancy, sickle cell, ADHD, diabetes, and ER/ED visits to evidence the successful and ongoing implementation of this requirement.	
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. The MCO provided many brochures and pamphlets, including for pregnancy, sickle cell, ADHD, diabetes, ER/ED visits, as well as the welcome packet, to evidence the successful and ongoing implementation of this requirement.	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. The member handbook details the member incentive program to encourage members to develop healthy behaviors on page 32. The MCO's brochures about perinatal care and chronic health conditions also include information about member self-management. The MCO's newsletters also	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
					include information for members to take charge of their own health and develop heathy self-management habits for conditions like high blood pressure and diabetes.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. The member handbook includes information about health coaches available to educate members with chronic conditions for self-care on page 39. The MCO also provided a sample brochure for a baby shower aimed to educate new mothers. The MCO also provided a new member postcard that invites members to an educational event about how to utilize the MCO's services and benefits.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. The MCO provided many brochures and pamphlets for members, including for pregnancy, sickle cell, ADHD, diabetes, ER/ED visits, as well as the welcome packet, to evidence the successful and ongoing implementation of this requirement.	
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		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. The member handbook includes chronic care management information on page 39. The MCO provided a brochure for members who were recently prescribed ADHD medication. For providers, the MCO provided an integrated care assessment brochure and	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
					communications about better care management for patients with acute, chronic, behavioral health care needs.	
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 Policy for member education		Full	This requirement is addressed in the Member Education Requirements Policy on page 5. Upon request pre-onsite, the MCO submitted sample notification to members about added dental benefits starting February 1, 2019 in English and in Spanish, as well as mailing proofs dated 12/27/2018 (English) and 12/12/2018 (Spanish), which evidence the implementation of this requirement.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	Policy for member education		Full	This requirement is addressed in the Member Education Requirements Policy on page 5.	
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (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 addressed in the two member handbooks (integrated and BH) provided by the MCO.	
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.	
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, and an explanation of how the enrollees can	Member Handbook		Full	This requirement is addressed in the member handbook, specifically for enrollee rights (pages 57 and 58), appropriate utilization of services (page 46), BH services (page 18), PCP selection process and the PCP's role as coordinator of services (pages 24 and 25).	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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;					
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 page 60.	
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 24.	
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 pages 24 and 27.	
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 pages 57 and 58.	
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 10 to 23.	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook		Full	This requirement is addressed in the member handbook on pages 14 and 42.	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook		Full	This requirement is addressed in the member handbook on page 8.	
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 page 22.	
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);	Member Handbook		Full	This requirement is addressed in the member handbook on pages 46 and 47.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	• 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 pages 46 and 47.	
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 27.	
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 23; access information for coordinates system of care, dental services for children, and adult long-term personal care services are listed.	
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 57.	
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		Not applicable	There are no counseling or referral services not covered because of moral or religious objections.	
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 49 to 54.	
12.12.1.19	Grievance, appeal and fair hearing procedures	Member Handbook		Full	This requirement is addressed in the	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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 on pages 49 to 54.	
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, 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	Member Handbook		Full	This requirement is addressed in the member handbook on pages 40 and 41.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan 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**
	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 page 59.	
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		Substantial	The first part of this requirement is addressed in the member handbook on page 25. The importance of canceling or rescheduling appointments is not mentioned in the handbook. **<u>Recommendation</u>** The MCO should include this requirement in its entirety in the member handbook.	We are updating our Member Handbook to fully address canceling/rescheduling instead of being a "no show" and will submit to LDH for approval by 09/13/2019. Once approved, we will post the new version of the handbook on the website and begin production on hard copies.
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 page 6.	
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 page 29.	
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 11 and 14.	
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 56.	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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 56.	
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 page 8.	
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 English version of the member handbook on page 31 and in the Spanish version of the member handbook on page 34.	
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 43.	
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 55.	
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook		Full	All additional information noted in the member handbook was approved by LDH.	
12.12.1.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed in the member handbook on page 2.	
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 marketing violations to LDH utilizing the Marketing Complaint Form.	Member Handbook		Full	This requirement is addressed in the member handbook on pages 54 (reporting alleged marketing violations), 57 (information about the MCO, physician incentive programs, service utilization policies) and 79 (marketing complaint form).	
12.12.1.35	Information regarding specialized behavioral	Member handbook		Full	This requirement is addressed in the	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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 on pages 18 to 20.	
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 page 56.	
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 new member materials, the member handbook, and the member newsletters, which inform members of the member materials (including the member handbook) available online.	
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;			Not applicable	This requirement is addressed by compliance with 12.12.1.37.3.	
12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;			Not applicable	This requirement is addressed by compliance with 12.12.1.37.3.	
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 new member materials, the member handbook, and the member newsletters, which inform members of the member materials (including	

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan 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 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.			Not applicable	This requirement is addressed by compliance with 12.12.1.37.3.	
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		Full	This requirement is addressed in the Member Handbook Policy on page 7. This requirement is evidenced in member newsletters (2018 and 2019), which inform members that they can access the member handbook online or receive a hardcopy upon request. The new member welcome packet also includes this information about obtaining the member handbook on page 11. The Member Education Requirements Policy indicates that at least once a year, current members will be notified of their right to request and obtain the welcome packet on page 5. Upon request pre-onsite, the MCO provided proof of mailing of the Spring 2019 newsletter, which evidences the implementation of this requirement during the review period.	
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		Full	This requirement is addressed in the Member Handbook Policy on page 7. Date of revision of the member handbook is listed as December 11, 2018 on page 2 of the handbook. An email between the MCO and LDH was provided as evidence of timely approval.	
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	Policy for Provider Directory		Full	This requirement is addressed in the provider Directory for Members Policy on	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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 Directory			page 1.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	Policy for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed in the provider Directory for Members Policy on page 1. The MCO provided a pdf version of the hard copy of the provider directory for members to evidence the implementation of this requirement.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	Policy for Provider Directory Provider Directory (website link)		Full	This requirement is addressed in the provider Directory for Members Policy on page 1. The provider directory is searchable for members and the public at https://providersearch.louisianahealthconnect.com/ The MCO provided screenshots demonstrating that the provider directory is web-based searchable and web-based machine readable.	
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	Policy for Provider Directory Provider Directory (electronic file format)		Full	This requirement is addressed in the Provider Directory for Members Policy on page 1. The MCO submitted the electronic file (MS Excel) version of the provider directory to evidence the implementation of this requirement.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	Policy for Provider Directory Provider Directory (abbreviated hard copy)		Full	This requirement is addressed in the provider Directory for Members Policy on page 1. The MCO provided the abbreviated hard copy (pdf version) of the provider directory for the Enrollment Broker to evidence the implementation of this requirement.	
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	Policy for Provider Directory		Full	This requirement is addressed in the provider Directory for Members Policy on page 1.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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.					
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 has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the provider Directory for Members Policy on page 2 and mostly evidenced in the hardcopy, electronic and online provider directories. The MCO provided screenshots of the online provider directory which show the cultural competency of providers who have completed training, specific to each culture trained on.	
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	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the provider directory for Members Policy on page 2. The online provider search, the electronic and hard copy versions of the directory all have relevant information for this requirement. Child serving providers and specialists in different settings can be searched online with ease. Hard copy indicates pediatricians under PCPs.	

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	types shall be delineated by parish and zip code;					
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the provider Directory for Members Policy on page 2, in the member handbook on pages 24 and 27, and in the hard copy version of the provider directory for members on page 1.	
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).	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the provider directory for Members Policy on page 2 and evidenced in all formats of the provider directory.	
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.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Member Handbook Policy on pages 2 (rights) and 5 (responsibilities). The new member packet also includes member rights (page 18) and responsibilities (page 19). The provider manual also includes member rights and responsibilities on pages 24 and 25. Upon request pre-onsite, the MCO also submitted the corporate and LA policies for members rights and responsibilities, which evidence the implementation of this requirement.	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the member handbook on pages 57 and 58 and in the provider manual on pages 24 and 25.	
12.17.16	**Member Responsibilities**					
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate	Policy for Member Rights and Responsibilities Member Handbook Provider Manual		Full	This requirement is addressed in the member handbook on page 58.	

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan 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**
	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.	Provider Contract Contractor Contract				
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.	Policy for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed in the member handbook on page 58.	
12.18	**Notice to Members of Provider Termination**					

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Plan 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**
12.18.1	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.	Policy for Provider Termination Policy for notifying members of provider termination		Full	This requirement is addressed in the Notice to Members of Provider Termination Policy on page 1. Upon request pre-onsite, the MCO submitted sample notifications to members regarding the termination of their provider, which meet this requirement. The notifications are dated March 13, 2019. The provider was terminated 03/15/19	
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.	Policy for Provider Termination Policy for notifying members of provider termination		Full	This requirement is addressed in the Notice to Members of Provider Termination Policy on page 1. Upon onsite discussion, the MCO provided evidence of a terminated provider dated 04/10/2018 with an accompanying letter to a member dated 04/17/2019, which meets this seven (7) calendar day requirement.	
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	Policy for oral and written interpretation services Policy for notification of member of interpretation		Full	This requirement is addressed in Interpretation and Translation Services Policy on page 1. The member handbook informs the members of their right to oral	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan 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
	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.	services and how to access the services			interpretation on page 58.	
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).	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in Interpretation and Translation Services Policy on page 1. The member handbook informs the members that translations are available in 15 languages on pages 89 to 91. The Spanish information includes that the translation is available at no cost.	
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. Large print means printed in a font size no smaller than 18 point.	Policy for Member Rights and Responsibilities		Full	This requirement is addressed in Interpretation and Translation Services Policy on page 1.	

Member Grievance and Appeals

Member Grievance 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 LA.QI.11.02 Grievance Process.	
13.2.2	**Filing Requirements**					
13.2.2.1	**Authority to File**					
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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		Substantial	This requirement is substantially addressed in LA.QI.11.02 Grievance Process. The member handbook appropriately conveys the 60-day timeframe on page 49; however, the appeal form on page 72 indicates the following: "To file a grievance or appeal, please complete this form and send it to us within 30 days of the event or	We will show consistency by updating the member handbook to reflect the 60 day timeframe in the grievance and appeal form on page 72; and will submit to LDH for approval on 09/13/2019. Once approved, we will post the

Member Grievance 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
					denial letter." This guidance should reflect the 60 days as outlined in the requirements. **Recommendation** LHCC should ensure consistency throughout the member handbook by indicating the 60-day timeframe in the grievance and appeal form on page 72.	new version of the handbook on the website and begin production on hard copies.
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in writing with either LDH or the MCO.	P/P for Grievances		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	

Member Grievance 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
	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.					
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 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.	P/P for monthly reporting of grievances and appeals including sample report format		Full	This requirement is addressed in LA.QI.11.02 Grievance Process, and evidenced in LHCC's Grievance Tracking Form.	
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 LA.QI.11.02 Grievance Process.	
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 File Review and Member Appeal File		Substantial	This requirement is addressed in LA.QI.11.02 Grievance Process. **File Review Results** Fourteen (14) of 15 grievance files and 10 of 10 appeal files met this requirement. One grievance file demonstrated that the	We have a monthly acknowledgement letter audit program in place with consequences.

Member Grievance 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			member was given verbal acknowledgement within five days; however, written acknowledgement was issued in seven days. **Recommendation** LHCC should ensure timely written communication is issued to members following receipt of grievance.	
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 LA.QI.11.02 Grievance Process and in LA QI.11.03 Appeal Process.	
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 and Member Appeal File Review		Full	This requirement is addressed in LA.QI.11.02 Grievance Process. **File Review Results** Thirteen (13) of 15 grievance files were not applicable. The remaining two files met this requirement. Ten (10) of 10 appeal files met this requirement.	
13.4.2	**Special Requirements for Appeals**					

Member Grievance 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 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 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.	P/P for Appeals Member Handbook Confirmation Letter Template		Full	This requirement is addressed in Attachment B – Oral Appeals & Written Notification, as well as within the MCO's verbal appeal letter template (seeking written confirmation for non-urgent appeals). LHCC has established a process wherein they request the member file a written appeal (following verbal request) within 15 days of when the letter requesting such confirmation from the MCO is received by the member. The MCO will count the oral request as the first day the appeal was filed, although they will not start their review process until the written request is received. The letter does cite the 30-day resolution standard, which begins once the oral request is received.	
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 LA.QI.11.03 Appeal Process. **File Review Results** Ten (10) of 10 appeal files met this 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	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 LA.QI.11.03 Appeal Process. **File Review Results** Ten (10) of 10 appeal files met this requirement.	

Member Grievance 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
	resolve the appeal.					
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 LA.QI.11.03 Appeal Process. **File Review Results** Ten (10) of 10 appeal files met this 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 providers.	Training Agendas and attachments Sign-in sheets		Full	This requirement is addressed in LA.QI.11.02 Grievance Process and demonstrated in the new employee orientation PowerPoint.	
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	This requirement is addressed in LA.QI.11.02 Grievance Process and in the responsibilities outlined in the job description for Grievance & Appeals Coordinator.	
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 LA.QI.11.02 Grievance Process.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	P/P for Appeals P/P for Fair Hearing Appeal Resolution Notice		Full	This requirement is addressed in LA.QI.11.02 Grievance Process and is communicated to members on Page 51 of the member handbook, as well as in the MCO's appeal resolution notice.	
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.	Notice of Action Includes Member		Substantial	This requirement is addressed in LA.QI.11.02 Grievance Process and evidenced in the Notice of Action letter.	Education email sent to all Clinical Appeal Coordinators citing Audit

Member Grievance 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
	§438.10 and Section 12 of this RFP to ensure ease of understanding.	Grievance File Review and Member Appeal File Review			**File Review Results** Fourteen (14) of 15 grievance files and 10 of 10 appeal files met this requirement. One grievance file indicated that the member's PCP was "termed" and that was why they no longer could see that provider. **Recommendation** LHCC should ensure the reading level of the Notice of Action letter is appropriate to facilitate ease of understanding.	Element UM 9D providing instruction to always provide specific reason for the appeal decision in easy understandable language. Accreditation SharePoint site has some useful tools: https://cnet.centene.com/sites/Accreditation Please utilize the Medical Terminology in 6th Gr Language to ensure letters are in understandable language. This area is HIGHLY scrutinized. Education email sent to all Grievance and Appeal Coordinators showing the recommendation from IPRO to ensure all acknowledgement and resolution letters are easily read and in a 4th grade level. Teamed with marketing who are currently revamping our letters and will incorporate prefilled drop down boxes with common grievance received.
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:					
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	

Member Grievance 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
		Includes Member Grievance File Review and Member Appeal File Review			**File Review Results** Fifteen (15) of 15 grievance files and 10 of 10 appeal files met this 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 LA.QI.11.02 Grievance Process. **File Review Results** Ten (10) of 10 appeal files met this 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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process. **File Review Results** Ten (10) of 10 appeal files met this requirement.	
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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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		Full	This requirement is addressed in LA.QI.11.02 Grievance Process. **File Review Results** Ten (10) of 10 appeal files met this requirement.	
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		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
13.5.3	**Timing of Notice of Action**					

Member Grievance 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 MCO must mail the Notice of Action within the following timeframes:					
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action,:	P/P for Notice of Action		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
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		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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	P/P for Notice of Action P/P for Notice of Action for Standard Service Authorizations P/P for Handling Extensions		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	

Member Grievance 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
	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.	Notice of Decision to Extend Timeframe				
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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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 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.	P/P for Notice of Action P/P for Notice of Action for Expedited Service Authorizations		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
13.5.3.9	The MCO may extend the seventy-two (72) hours	P/P for Notice of Action		Full	This requirement is addressed in LA.QI.11.02	

Member Grievance 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
	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 Handling Extensions Notice of Decision to Extend Timeframe			Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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 Includes Member Grievance File Review		Full	This requirement is addressed in LA.QI.11.02 Grievance Process. **File Review Results** Fifteen (15) of 15 grievance files met this requirement.	
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 Appeal File Review		Full	This requirement is addressed in LA.QI.11.03 Appeals Process. **File Review Results** Ten (10) of 10 appeal files met this 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 under Section 13.6.2 of this Section.	P/P for Appeals Includes Member Appeal File Review		Full	This requirement is addressed in LA.QI.11.03 Appeals Process. **File Review Results** Ten (10) of 10 appeal files met this 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:	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to		Full	This requirement is addressed in LA.QI.11.03 Appeals Process and in LA.QI.11.02 Grievance Process.	

Member Grievance 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 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.	Extend Timeframe Member Appeal File Review			**File Review Results** Ten (10) of 10 appeal files were not applicable.	
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 Member Appeal File Review		Full	This requirement is addressed in LA.QI.11.02 Grievance Process. File Review Results Ten (10) appeal files were reviewed, and all were not applicable as there was not an extension made on behalf of the MCO. **File Review Results** Ten (10) of 10 appeal files were not applicable.	
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 LA.QI.11.02 Grievance Process.	
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. **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.	P/P for Grievances P/P for Appeals Resolution Notice		Full	This requirement is addressed in LA.QI.11.02 Grievance Process and in LA.QI.11.03 Appeals Process.	
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.	P/P for Appeals Resolution Notice		Full	This requirement is addressed in LA.QI.11.03 Appeals Process.	

Member Grievance 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
	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.					
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 LA.QI.11.03 Appeals Process.	
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 LA.QI.11.03 Appeals Process.	
13.7	**Expedited Resolution of Appeals**					
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	P/P for Appeals		Full	This requirement is addressed in LA.QI.11.03 Appeals Process.	
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,	P/P for Appeals Provider Handbook		Full	This requirement is addressed in LA.QI.11.03 Appeals Process and communicated to providers via the provider manual on page 127.	

Member Grievance 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
	who requests an expedited resolution or supports a member's appeal.					
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 LA.QI.11.03 Appeals Process.	
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		Substantial	This requirement is partially addressed in LA.QI.11.02 Grievance Process. During onsite interviews, it was determined that LHCC needs to revise policy LA.QI.11.03 Appeals Process so that it includes the required language. That policy has been updated as of August 2019 and submitted for review. **<u>Recommendation:</u>** LHCC should finalize this updated version of the Appeals process policy and distribute to staff as appropriate.	The Appeals Process policy, LA.QI.11.03 was revised to include the wording from the RFP on August 26th & has already been approved by the state.
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The	P/P for Appeals		Full	This requirement is addressed in LA.QI.11.03 Appeals Process.	

Member Grievance 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 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.					
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 LA.QI.11.03 Appeals Process. The option of an expedited appeal request is communicated to members in the member handbook on page 50.	
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 the member handbook on page 49.	
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 Includes Member Appeal File Review		Full	This requirement is addressed in LA.QI.11.03 Appeals Process. **File Review Results** Six (6) of 10 appeal files were not applicable. The remaining 4 files met this requirement.	
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	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in LA.QI.11.03 Appeals Process.	

Member Grievance 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
	authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and • The member requests extension of benefits.					
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 LA.QI.11.03 Appeals Process.	
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 LA.QI.11.03 Appeals Process. In terms of the member's responsibility to cover costs while the appeal is pending, this is partially communicated in the member handbook on page 51 as follows: "If the state fair hearing finds our decision was right, you may be responsible for the cost of the continued services."	
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 LA.QI.11.02 Grievance Process, in the provider manual on page 127, and in the Participating Provider Agreement.	

Member Grievance 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	**Recordkeeping and Reporting Requirements**					
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	P/P for Grievances P/P for reporting grievances and resolutions to DHH Report Format		Full	This requirement is addressed in LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	
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 LA.QI.11.02 Grievance Process.	

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 QAPI Program Description on page 8.	
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 QAPI Program Description on page 3.	
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the QAPI Program Description on page 15, in the context of the Medical Management Committee 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 LHCC's Quality Improvement Strategies document, which details the following three topic areas: Psychotropic Medication Utilization Review Program, Attention Deficit Hyperactivity Disorder (ADHD) Initiative, and portable oxygen coverage.	
14.1.7	The MCO shall reduce underutilization of services	QAPI Program Description		Full	This requirement is evidenced in the	

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
	in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.	QAPI Work Plan			prematurity and ADHD PIPs submitted by the MCO.	
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 Psychotropic Medication Utilization Review (PMUR) Overview and in LA.PMN.01, Appropriate Use and Safety Edits.	
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 QAPI Program Description on page 1.	
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 provider visit record form, which contains a question pertaining to EHRs and the provider's current use. LHCC – incentive-based projects, health fair in a box, partner with provider, care management, and focus on providers with care gaps and large populations. LHCC works with providers to identify target issues and help focus, including back to school, immunization, targeting of older patients, and diet and exercise. Incentives include a member gift card if they do the screening. These incentives help providers close gaps to qualify for VBP. Care management team is working with hospital groups on EMR. EPIC EMR -	

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
14.1.11	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		Substantial	This requirement is evidenced in the 2019 Population Analysis Report. This requirement is partially addressed in the QAPI Program Description on page 1, which states that "Louisiana Healthcare Connections incorporates all demographic groups . . . in its quality improvement activities." The methodology utilized for collecting these data, as well as actions taken to enhance accuracy, are not evident. In our onsite interview, LHCC provided specific examples of how they use data to identify quality gaps and improvement opportunities (i.e., CLASS Committee looks at HEDIS data and breakdown by region, age group, ethnicity, etc. and identified gaps, found issues with Vietnamese community, and created intervention focused on these groups). **Recommendation** LHCC should ensure that their QAPI Program Description includes their methodology for collecting demographic data, as well as the ways these data inform the decisions made in targeting their quality initiatives to specific identified needs.	Verbiage will be added to the Quality Program Description to describe the methodology for stated demographic data and the ways these data inform the decisions made in targeting our quality initiatives to specific identified needs as requested by IPRO and we will present at our next QAPIC committee on 9/27/2019 for approval.
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 selection of QAPI activities.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed throughout the QAPI Program Description and QI Work Plan.	

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
14.1.13	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 evidenced throughout the QAPI Program Description and QI Work Plan.	
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 QAPI Program Description on pages 6, 8, and 39.	
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 evidenced throughout the QAPI Program Description and in the Medicaid Quality Committee meeting minutes and Member Satisfaction Survey findings.	
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 evidenced in the LDH report submissions provided by LHCC (namely, 136 LHCC 2018).	
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 increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Clinical guidelines for ADHD Provider education Provider manual		Full	This requirement is addressed in the Adopted Clinical Practice and Preventive Health Guidelines and in the provider manual. Further, the MCO is conducting in a collaborative PIP that seeks to increase alignment with best practices for ADHD care for children.	
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 CC.QI.19, Peer Review Committee and Process.	
14.1.20	The MCO shall participate in the LDH	IMT meeting minutes		Full	This requirement is addressed in LHCC taking	

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
	Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.				part in the required quality improvement meetings with LDH.	
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 evidenced in Report 355 LHCC 2018 SA2 and Report 355 LHCC 2019 SA1.	
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 evidenced in Report 355 LHCC 2018 SA2 and Report 355 LHCC 2019 SA1.	
14.2	**QAPI Committee**					
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:					
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the QAPI Program Description on page 6.	
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the QAPI Program Description on page 9.	
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 QAPI Program Description on page 9.	
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 QAPI Program Description on page 9.	

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
14.2.1.5	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 QAPI Program Description on page 9.	
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 QAPI Program Description on page 9, and in the QI Work Plan.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on page 9, and in the QI Work Plan.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on pages 8 and 9.	
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on page 9.	
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 QAPI Program Description on page 9.	
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on pages 9 and 52.	
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 QAPI Program Description on page 25 in the context of the Provider Engagement Committee, which reports directly to QAPIC.	
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 QAPI Program Description on page 5.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on page 49.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to LDH;	QAPI Program Description		Full	This requirement is addressed in the QAPI Program Description on page 10.	
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 QAPI Program Description on page 10 and evidenced in the QAPI Annual Evaluation, which refers to the Case Management Program Evaluation that is sent to the QAPIC	

Quality Management						
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					through the Medical Management Committee on an annual basis. This annual evaluation of the CM Program addresses the CM Program's staffing, training, policies, processes, standards, goals, actions, and outcomes throughout the preceding year.	
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description		Full	This requirement is evidenced in the Medicaid Quality Committee meeting minutes.	
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 QAPI Program Description on page 8.	
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 evidenced in the QAPI Work Plan.	
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 evidenced in the QAPI Work Plan.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description		Full	This requirement is evidenced in the QAPI Work Plan.	
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 QAPI Program Description and evidenced in the QAPI Work Plan.	
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 QAPI Program Description and evidenced in the QAPI Work Plan.	
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 evidenced in the QAPI Work Plan.	
14.2.3.6	Describe the methods for ensuring data collected	QAPI program description		Full	This requirement is addressed in the QAPI	

Quality Management						
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	and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.				Program Description on pages 1, 46, and 47. This requirement is also evidenced in report 356 LHCC 2018, which demonstrates the MCO's IRR practices, and in the 2018 Fidelity to Evidence-Based Practices Monitoring Plan.	
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 2018 Fidelity to Evidence-Based Practices Monitoring Plan.	
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 QAPI Program Description on pages 43-44 and evidenced in the QAPI Work Plan.	
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	This requirement is addressed in the QAPI Program Description on page 53.	
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	This requirement is addressed in the QAPI Program Description on page 4 and evidenced in the LHCC IDSS.	
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 throughout the QAPI Program Description.	
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 QAPI Program Description on page 47.	

Quality Management						
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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 QAPI Program Description on page 40.	
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 QAPI Program Description on page 40.	
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		Full	This requirement is addressed in the QAPI Program description on pages 1, 46, 47, and 62. This requirement is also evidenced in Report 356 LHCC 2018, which demonstrates the MCO's IRR practices, and in the 2018 Fidelity to Evidence-Based Practices Monitoring Plan.	
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 Excel file that outlines the LHCC non-HEDIS measures and corresponding rates for incentive based measures	
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		Full	This requirement is evidenced in the QAPI Program Description on page 44.	
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 QAPI Program Description on page 49.	

Quality Management						
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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 QAPI Program Description on page 49.	
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 QAPI Program Description on page 53.	
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 QAPI Program Description on page 51 and evidenced by the performance measures reflected in the PIPs submitted by the MCO during the measurement period.	
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs 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.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the QAPI Program Description on page 44.	
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 QAPI Program Description on pages 44 and 51.	
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;	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the QAPI Program Description on page 51 and evidenced by the PIPs submitted by the MCO during the measurement period.	

Quality Management						
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	• Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.					
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 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.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the QAPI Program Description on page 52 and evidenced by the PIPs submitted by the MCO during the measurement period.	
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	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is evidenced in LHCC's run charts for their intervention tracking measures, their collaborative ADHD PIP interim report, their IET PIP proposal, and their collaborative prematurity PIP final report.	

Quality Management						
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	and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.					

Quality Management						
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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 the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	
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 LHCC having contracted with Morpace, an NCQA-certified CAHPS vendor.	
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS report		Full	This requirement is addressed in the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	
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 the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used		Full	This requirement is evidenced in the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	
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 evidenced in the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	
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,	CAHPS reports		Full	This requirement is evidenced in the 2018 Child CAHPS Summary Report and in the 2018 Adult CAHPS Summary Report.	

Quality Management						
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	.4 Health Plan Customer Service, .5 Global Ratings.					
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 evidenced in the 2018 Behavioral Health Member Satisfaction Survey Report.	
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 evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report, which demonstrates an accreditation status of Commendable.	
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 evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report.	
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 evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report.	
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 evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report.	
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 evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report.	
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of accreditation report if		Full	This requirement is evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report.	

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		accredited				
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	This requirement is evidenced in LHCC's 2018 NCQA Certificate and Accreditation Summary Report, which demonstrates an accreditation status of Commendable.	
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 and responsibilities		Full	This requirement is addressed in the QAPI Program Description on page 34 and in Policy LA.MBRS.05, Member Advisory Council.	
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		Full	This requirement is addressed in the QAPI Program Description on page 34 and in Policy LA.MBRS.05, Member Advisory Council.	
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 QAPI Program Description on page 34 and in Report 141 LHCC 2018 A.	
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		Full	This requirement is addressed in Policy LA.MBRS.05, Member Advisory Council.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of	Member Advisory Council Plan		Full	This requirement is addressed in Report 141 LHCC 2018 A in the attachment related to	

Quality Management						
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	meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.	Evidence of timely submission of a Member Advisory Council Plan			the Member Advisory Council Plan submitted to LDH on January 25, 2019.	
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		Full	This requirement is addressed in Policy LA.MBRS.05, Member Advisory Council, and evidenced in the MCO's website.	
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 Fidelity to Evidence-Based Practices Monitoring Plan and demonstrated in the MOUs between LHCC and FFT, MST, and ACT. LHCC has provider quality monitoring. For SUD, they do a LOC and risk assessment, going out with MRR. There is random selection of providers. They follow a strategy to see at least 15% and to look for QOC issues to target the sample. Also, there are referrals with UM. In the desk review and onsite, LHCC quality team can determine if the documentation is elsewhere. Team will educate the team, but if QOC issue is flagrant, then this issue gets escalated.	
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. The MCO shall ensure their staff are properly	Fidelity monitoring plan Evidence of submission to LDH		Full	This requirement is addressed in the Fidelity to Evidence-Based Practices Monitoring Plan.	

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	trained on utilization of the identified ACT Monitoring tool.					
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	This requirement is addressed in the Fidelity to Evidence-Based Practices Monitoring Plan and in Report 355 LHCC 2018.	
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 LA.QI.34, Adverse Incidents.	
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 incident management.					

Quality Management						
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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 Policy LA.QI.34, Adverse Incidents.	
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 Report 356 Provider Quality Monitoring Plan.	
14.9.1.1	Review criteria for each applicable provider type/level of care;			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
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 Report 356 Provider Quality Monitoring Plan.	
14.9.1.3	Member interview criteria;			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
14.9.1.4	Random audit selection criteria;			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
14.9.1.5	Tools to be used;			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
14.9.1.6	Frequency of review, including schedule of reviews by provider type;			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
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 Report 356 Provider Quality Monitoring Plan.	
14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	

Quality Management						
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14.9.1.9	Inter-rater reliability testing methods.			Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan.	
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 Report 356 Provider Quality Monitoring Plan.	
14.9.3	The MCO's review criteria shall address the following areas at a minimum:					
14.9.3.1	Adherence to clinical practice guidelines;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.3	Cultural competency;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.4	Patient safety;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.5	Compliance with adverse incident reporting requirements;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment 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'			Full	This requirement is addressed in the PQM Audit Tool (updated 3/20/2019).	

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
	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 the PQM Audit Tool (updated 3/20/2019).	
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 monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.	Provider Monitoring P/P		Full	This requirement is addressed in LA.QI.35, Behavioral Health Provider Quality Monitoring Program.	
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for	Provider Monitoring P/P Provider Monitoring Reports		Full	This requirement is addressed in Report 356 Provider Quality Monitoring Plan Strategy, which states that the MCO reviews SBH	

Quality Management						
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	Specialized Behavioral Health Services.				providers and reports their findings quarterly in the LDH-OBH Provider Monitoring Summary Report Template. Further, this requirement is demonstrated in Provider Monitoring Report LA 358.	
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 MCO's annual report entitled QAPI Performance Improvement Projects (outcomes), as well as in Report 044 LHC 2018 A.	
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 MCO's annual report entitled QAPI Performance Improvement Projects (outcomes), as well as in Report 044 LHC 2018 A.	
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 MCO's annual report entitled QAPI Performance Improvement Projects (outcomes), as well as in Report 044 LHC 2018 A.	

Fraud, Abuse, and Waste Prevention

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	**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 Fraud, Waste and Abuse Plan on pages 1 and 2. The meetings are indicated to be quarterly (which also fulfills the annual requirement) and at LDH's request.	
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 Fraud, Waste and Abuse Plan on page 2.	

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 Fraud, Waste and Abuse Plan on page 2.	
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 Fraud, Waste and Abuse Plan on page 2.	
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 Fraud, Waste and Abuse Plan on page 3.	

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 Fraud, Waste and Abuse Plan on page 3.	
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 Fraud, Waste and Abuse Plan on page 3.	
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 Fraud, Waste and Abuse Plan on page 3 and in the Ownership and Management Disclosure Policy on pages 3 and 4. The Disclosure of Ownership and Control Form asks for disclosure of "the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity."	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 3.	

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
	place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.					
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall 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.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 3. The Disclosure of Ownership and Control Form indicates that any changes in disclosures must be reported to the MCO within 30 days of change.	
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 Fraud, Waste and Abuse Plan on page 4, in the Disclosure of Ownership and Control Forms Exclusion Screening Policy on page 1, and in the Monthly Employee, Vendor, and Board Member Exclusion Screening Policy on page 1.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 4.	

Fraud, Abuse, and Waste Prevention						
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	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 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 Fraud, Waste and Abuse Plan on page 4.	
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 Fraud, Waste and Abuse Plan on page 4.	
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 Fraud, Waste and Abuse Plan on page 4.	
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 Fraud, Waste and Abuse Plan on page 4.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 4.	

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
	is prohibited under this Section, the MCO will return the funds to LDH.					
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 15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..	FWA Compliance Plan Payment Suspension Policy		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 5. The MCO also submitted an email as an example of conferring with LDH before initiating recoupment on 12/20/2018.	
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 Fraud, Waste and Abuse Plan on page 5.	
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 Fraud, Waste and Abuse Plan on pages 5 and 6.	
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 Fraud, Waste and Abuse Plan on page 6.	
15.1.18.4.1	All tips (regarding any potential billing or claims issue identified through either complaints or	FWA Compliance Plan Evidence of report		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 6. The MCO	

Fraud, Abuse, and Waste Prevention						
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	internal review received within the previous month) shall be reported to LDH Program Integrity monthly; LDH	submission			submitted an email evidencing the submission of the tips report on 2/15/2019.	
15.1.18.4.2	Suspected fraud and abuse in the administration of the program shall be reported to LDH Program Integrity and MFCU;	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 6.	
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 Fraud, Waste and Abuse Plan on page 6.	
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 Fraud, Waste and Abuse Plan on page 6.	
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 Fraud, Waste and Abuse Plan on page 6. The MCO submitted the template referral form for provider fraud as well as an actual provider referral to evidence the implementation of this requirement.	
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 Fraud, Waste and Abuse Plan on page 6.	
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 Fraud, Waste and Abuse Plan on page 6.	

Fraud, Abuse, and Waste Prevention						
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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 Fraud, Waste and Abuse Plan on page 7.	
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 Fraud, Waste and Abuse Plan on page 7.	
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 Fraud, Waste and Abuse Plan on page 7.	
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 Fraud, Waste and Abuse Plan on page 7.	
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 Fraud, Waste and Abuse Plan on page 7.	
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	FWA Compliance Plan Provider Agreement Form		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 7. Provider Agreement meets this requirement in Attachment A: Medicaid on page 20.	

Fraud, Abuse, and Waste Prevention						
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	with this Section, Section 15 of this Contract.					
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 ability of providers to participate in the program for program integrity reasons.	FWA Compliance Plan Provider Enrollment, Disclosure & Credentialing Forms		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 7 and in the Practitioner Disciplinary Action and Reporting Policy, Attachment C on page 20.	
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 Fraud, Waste and Abuse Plan on page 8. After an onsite discussion, LHCC provided email correspondence between LHCC and LDH dated 04/02/2019 as evidence of timely reporting to LDH. This email correspondence included LHCC's bimonthly payment discrepancy report dated 03/26/2019.	
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 Fraud, Waste and Abuse Plan on page 8.	
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 Fraud, Waste and Abuse Plan on page 8.	
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the MCO's compliance program shall designate a	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 8.	

Fraud, Abuse, and Waste Prevention						
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	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. .					
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 Fraud, Waste and Abuse Plan on page 8, the Program Integrity/SIU Organizational Chart, and the resumes of the SIU team members.	
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 Fraud, Waste and Abuse Plan on page 8.	
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 Fraud, Waste and Abuse Plan on pages 8 and 9. The implementation of this requirement is evidenced by the Compliance Committee Charter and the Committee minutes for 3/26/2018, 6/18/2018, 9/17/2018, 12/17/2018, and 3/25/2019.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 9.	

Fraud, Abuse, and Waste Prevention						
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	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:					
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 the Fraud, Waste and Abuse Plan on page 9.	
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 Fraud, Waste and Abuse Plan on page 9.	
15.2.6.3	Enforcement through well-publicized disciplinary guidelines;			Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 9.	
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 Fraud, Waste and Abuse Plan on page 9.	
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 the Fraud, Waste and Abuse Plan on page 10.	
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 the Fraud, Waste and Abuse Plan on page 10.	
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 Fraud, Waste and Abuse Plan on page 10.	
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or			Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 10.	

Fraud, Abuse, and Waste Prevention						
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	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.					
15.2.6.9	Procedures for prompt notification to LDH when the MCO receives information about 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.			Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 10.	
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 Fraud, Waste and Abuse Plan on page 10.	
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 Fraud, Waste and Abuse Plan on page 10.	
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 Fraud, Waste and Abuse Plan on page 10.	
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 Fraud, Waste and Abuse Plan on page 11. The Fraud Waste and Abuse Annual Training 2018 dated 10/01/2018 evidences the annual training for all employees and the New Hire Compliance Training 2019 evidences training	

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
					materials. The Business Ethics and Code of Conduct document also includes Fraud, Waste and Abuse. The Compliance Committee meeting minutes evidence ongoing new hire and annual compliance training. During onsite discussions, LHCC explained in detail their new hire orientation process and tracking procedures to ensure that new hire orientation contains all necessary trainings within the first 30 days of employment.	
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 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,			Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 11. The New Hire Compliance Training 2019 evidences that training materials include parts of this requirement. The Compliance Committee meeting minutes evidence ongoing new hire training. During onsite discussion, LHCC explained that reconciliation of the Human Resources sign-in and Compliance Department training lists ensures all new employees receive the contractually required new hire training within the first 30 days of employment.	

Fraud, Abuse, and Waste Prevention						
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	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 the Fraud, Waste and Abuse Plan on page 11 and in the Claim Refund Check – Non-Centene Check Policy. The MCO provided the Refund Team Check Overpayment Workflow to evidence the process of how overpayment checks are processed. The MCO submitted the Provider Claim Dispute Form as evidence of the implementation of this process.	
	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 Fraud, Waste and Abuse Plan on page 11.	
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 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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 12.	

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
	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.					
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 Fraud, Waste and Abuse Plan on page 12.	
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 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)	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 13. The MCO submitted a sample email notifying LDH of an OIG sanction search result for a provider. The search reported a sanction effective 2/20/2019. The email notification to LDH was on 3/5/2019.	

Fraud, Abuse, and Waste Prevention						
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	(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 Fraud, Waste and Abuse Plan on page 13.	
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 Fraud, Waste and Abuse Plan on page 13.	
15.3.7	The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites referenced in 15.3.5 been completed to capture all exclusions.	FWA Compliance Plan Copies of monthly reports		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 13. The February 2019 attestations were submitted by the MCO as evidence of implementation of this requirement.	
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 Fraud, Waste and Abuse Plan on page 14.	
15.4.2	The MCO is responsible for the return to the State	FWA Compliance Plan		Full	This requirement is addressed in the Fraud,	

Fraud, Abuse, and Waste Prevention						
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	of any money paid for services provided by an excluded provider.				Waste and Abuse Plan on page 14.	
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 Fraud, Waste and Abuse Plan on page 14.	
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 Fraud, Waste and Abuse Plan on page 14.	
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, neglect and overpayments made to the MCO that warrant preliminary investigation (under 42 CFR 455.14);	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 14.	
15.5.3.2	Number of complaints reported to the Contract Compliance Officer; and	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 14.	
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;	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on pages 14 and 15.	

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
	• 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.					
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 Fraud, Waste and Abuse Plan on page 13. Sample attestations submitted by the MCO are evidence of the implementation of this requirement.	
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 Fraud, Waste and Abuse Plan on page 15. The quarterly reports submitted for the review period are evidence of the implementation of this requirement.	
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 Fraud, Waste and Abuse Plan on page 15. The quarterly reports submitted for the review period are evidence of the implementation of this requirement.	
15.5.6	LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 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:	Policy for medical records Policy for medical record documentation standards Policy for medical record monitoring Provider Manual Model Provider Contracts for all provider types		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on page 1.	
15.6.1.1	Accurate and legible;	Policy for medical records Policy for medical record		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the	

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
		standards			Medical Record Review Policy on page 1.	
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	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on pages 1 and 11.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on pages 1 and 11.	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on pages 1 and 11.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on page 11.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on page 11.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 15 and in the Medical Record Review Policy on page 11.	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
15.6.2.7	Signed and dated consent forms (as applicable);	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	

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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
15.6.2.8	Documentation of immunization status;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
15.6.2.9	Documentation of advance directives, as appropriate;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
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.	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
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.	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 11.	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	Policy for medical records		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 16 and in the Medical Record Review Policy on page 4.	
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	Policy for medical records Policy for medical record retention		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 17 and in the Medical Record Review Policy on page 4. The 2018 Centene Records Retention Schedule included in the Records Management Policy indicates that medical records and record review results are retained for at least 10 years.	

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	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.					
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 Fraud, Waste and Abuse Plan on page 17.	
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 Fraud, Waste and Abuse Plan on page 17.	
15.7.3	All reviews shall be completed within eight 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.	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 17.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 17.	

Fraud, Abuse, and Waste Prevention						
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	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.					
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 Fraud, Waste and Abuse Plan on page 17.	
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 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 Fraud, Waste and Abuse Plan on page 18.	
15.7.8	LDH shall not initiate its own review on the same					

Fraud, Abuse, and Waste Prevention						
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	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 Fraud, Waste and Abuse Plan on page 18.	
15.7.10	In the event the State or its agent investigates or 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.	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 18.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 19.	

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
	overpayment by the Department or its agent unless directed to do so by the Department.					
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 Fraud, Waste and Abuse Plan on page 19.	
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.					
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 Fraud, Waste and Abuse Plan on page 19.	
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 Fraud, Waste and Abuse Plan on page 19.	
	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	FWA Compliance Plan Provider Enrollment and		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on pages 19 and 20.	

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	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.	Contract Forms			This requirement is also addressed in the Disclosure of Ownership and Control Forms Exclusion Screening, Monthly Employee, Vendor, and Board Member Exclusion Screening Policies. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
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, 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.	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 20.	
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 the Fraud, Waste and Abuse Plan on page 20.	

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
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 is addressed in the Fraud, Waste and Abuse Plan on page 20. This requirement is also addressed in the Practitioner Credentialing and Recredentialing Policy on pages 1, 2, 28, and 29. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 20. This requirement is also addressed in the Practitioner Credentialing and Recredentialing Policy on pages 1, 2, 28, and 29.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 20.	

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
	agent(s).					
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 Fraud, Waste and Abuse Plan on page 21.	
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 Fraud, Waste and Abuse Plan on page 21. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
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. 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,	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 21. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	

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
	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. 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	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on pages 21 and 22 and in the Ownership and Management Disclosure Policy on pages 1 and 4. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	

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
	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 Fraud, Waste and Abuse Plan on pages 21 and 22 and in the Ownership and Management Disclosure Policy on pages 1 and 4. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
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 (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 .	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on page 22 and in the Ownership and Management Disclosure Policy on page 4. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Fraud, Waste and Abuse Plan on pages 22 and 23 and in the Ownership and Management	

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
	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).				Disclosure Policy on pages 1 and 4. The Disclosure of Ownership and Control Form is evidence of the implementation of this requirement.	
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual; Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.	FWA Compliance Plan				

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	Centene MIS Data Flow Narrative_5.20.19.pdf Centene MIS Diagram 5.20.19.pdf IPRO LA MCO 18 Reporting Sampling.docx Reporting Examples.pdf	Full	This requirement is evidenced in the Centene MIS data flow narrative and in the Centene MIS diagram, with supporting screenshots demonstrating dashboard outputs that monitor utilization.	