Magellan of Louisiana

2019 Compliance Audit

Review Period: November 01, 2018 – April 30, 2019

Final Report Issued December 2019

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

IPRO
Better healthcare, realized.

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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). This requirement also applies to the conduct an external independent review of Magellan of Louisiana, a Prepaid Inpatient Health Plan (PAHP).

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 PAHP's compliance with contractual requirements during the period of November 1, 2018, through April 30, 2019.

This report presents IPRO's findings of the 2019 annual compliance audit for Magellan of Louisiana (Magellan).

Audit Overview

The purpose of the audit was to assess Magellan'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 Magellan's policies, procedures, files, and other materials corresponding to the following 10 contractual domains:

1. Member Services
2. Provider Network Requirements
3. Care Management
4. Utilization Management
5. Provider Services
6. Enrollment
7. Grievance and Appeal System
8. Quality Management
9. Program Integrity
10. Audits, Records, and Reports

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

Specifically, file review consisted of the following five areas:

1. Appeals
2. Case Management
3. Credential/Recredentialing
4. Member Grievances
5. Utilization Management

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Case Management	20
Credential/Recredentialing	20
Member Grievances	20
Utilization Management	15

The period of review was November 1, 2018, through April 30, 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 PAHP is compliant with the standard.
Substantial	The PAHP is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The PAHP is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The PAHP is not in compliance with the standard.
Not Applicable	The requirement was not applicable to the PAHP.

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 PAHP's policies and procedures, IPRO prepared 10 review tools to reflect the areas for audit. These 10 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 PAHP in April 2019 in advance of the onsite audit.

Once LDH approved the methodology, IPRO sent Magellan a packet that included the review tools, along with a request for documentation and a guide to help PAHP 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 PAHP with examples of documents that the PAHP 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 PAHP submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The PAHP was given a period of approximately four weeks to submit

documentation to IPRO. To further assist PAHP staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs and PAHPs undergoing the audit, with LDH staff in attendance, approximately two weeks after the request packet was sent to the MCOs and PAHPs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline, and answered any questions posed by MCO and PAHP staff.

After the PAHP submitted the required documentation, a team of three experienced IPRO auditors was convened to review the PAHP's policies, procedures, and materials, and to assess the PAHP'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 10 review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited Magellan on July 8 and 9, 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 PAHP to provide additional documentation, if available. File review, as indicated, was conducted to assess the PAHP's implementation of policy in accordance to state standards. PAHP 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 PAHP is compliant with the standard or a rationale for why the PAHP was not compliant and what evidence was lacking. For each element that was deemed not fully compliant, IPRO provided a recommendation for the PAHP to consider in order 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 PAHP with a request to provide responses for all elements that were determined to be less than fully compliant. The PAHP was given one week to respond to the issues noted on the draft reports.

After receiving the PAHP's response, IPRO re-reviewed each element for which the PAHP provided a response. As necessary, elements' review scores may have been updated based on the response of the PAHP.

PAHP Summary of Findings

Summary of Findings

Table 3 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]
Member Services	128	125	3	0	0	0	98%
Provider Network Requirements	72	59	6	6	0	1	83%
Care Management	44	44	0	0	0	0	100%
Utilization Management	35	35	0	0	0	0	100%
Provider Services	94	90	0	1	1	2	98%
Enrollment	11	10	1	0	0	0	91%
Grievance and Appeal System	76	71	3	1	1	0	93%
Quality Management	65	64	1	0	0	0	99%
Program Integrity	76	61	2	5	1	7	88%
Audits, Records, and Reports	1	1	0	0	0	0	100%
TOTAL	**602**	**560**	**16**	**13**	**3**	**10**	**95%**

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

As presented in **Table 3**, 602 elements were reviewed for compliance. Of those 602 elements, compliance status of 16 was determined to be "substantial," compliance status of 13 was determined to be "minimal," compliance status of 3 was determined to be "non-compliance," compliance status of 10 was determined to be "not applicable," while compliance status of the remaining 560 elements was determined to be "full." The overall compliance score for Magellan was 95% elements in full compliance.

IPRO extracted from each of the nine detailed reports those elements for which the PAHP 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 PAHP's initial response, and, when possible, recommendations to achieve full compliance.

It is the expectation of both IPRO and the LDH that Magellan submit a corrective action plan (CAP) for each of the 32 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Magellan has already implemented a corrective action for many of the areas identified for improvement in the report, but the corrections were made after the audit was completed and were not applicable to the audit's review period. Twelve (12) of the 32 elements rated less than fully complaint relate to network adequacy and the PAHP's ability to contract with providers in several specialty and sub-specialty areas–a problem for all Medicaid MCOs and PAHPs in Louisiana.

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**	**Review Determination**	**Reviewer Comments**	**MCO Response and Plan of Action**
Member Services				
5.6.1.5	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.	Substantial	This requirement was addressed via the on-site walkthrough of the website. Language regarding communication alternatives was observed. However, there was no evidence that the alternative forms of communication are provided at no expense to the member. **Recommendation** The PAHP should add language on its member portal that alternative forms of communication, reflecting the needs of members with the disabilities indicated in the regulation, are provided at no expense to the member.	Our Member Handbook has been updated to include additional information regarding free services and alternate forms of communication for Members with disabilities. Once approved by the LDH, this information will be included on our website, as well.
5.8.4.1 5.8.4.1.1 5.8.4.1.2 5.8.4.1.3 5.8.4.1.4 5.8.4.1.5	The Contractor shall prepare and distribute educational materials, including, but not limited to, the following: 1. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to providers and other information that is helpful to members; 2. Literature, including brochures and posters, such as calendars, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders; 3. Identify and educate members who access the system inappropriately and provide continuing education as needed.	Substantial	This requirement is addressed in the Member Education Plan Narrative. The PAHP does not have evidence of such educational materials as brochures, posters, calendars, or EDSTD outreach materials. Member Services handles members who access the system inappropriately. **Recommendation** The PAHP should consider some form of ongoing education of its members, for example, devoting a section of its website to presenting monthly tips, highlighting healthy practices. The PAHP should consider adding a calendar to the website, including reminders for routine services (e.g., flu shots, vaccinations, EPSTD services). The PAHP should include language on the website to educate members about how to use and access the website appropriately – for example, a "do's and don'ts" section.	Magellan's quarterly Member Newsletter is available on our website*. Our Fall and Winter editions will feature the topics IPRO recommended, including: • tips on navigating the website • EPSDT and mental health information • health plan-related information (e.g., contact information) • seasonal health items (e.g., flu shot reminder) * Wraparound Facilitators also share hard copy versions with Members.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	4. Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date in accordance with 42 CFR §438.10(g); and 5. All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.			
5.15.2	Member education materials shall be available in English, Spanish, and Vietnamese. In addition, the Contractor shall ensure that translation services are provided for written member education materials and provided in any language that is spoken as a primary language by at least five percent (5%) of Contractor members. LDH-BHSF will provide the Contractor with a list of prevalent non-English languages spoken by members by parish via the Preferred Language Statewide by Parish link. Written materials must also be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. 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 afford a reasonable chance for all members to understand how to access the Contractor and use services	Substantial	This requirement is addressed in the Non-discrimination and Language Access Policy, which provides a high-level explanation of the PAHP's translation and interpreter services. This policy does not explicitly address the 5% requirement, or the 90-day requirement. **Recommendation** The PAHP should update the Non-discrimination and Language Access Policy to include the language required in the standard.	Magellan's Nondiscrimination and Language Access policy has been updated to include this information.

Deficient 2019 Audit Elements				
Contract Reference	**Contract Requirement Language**	**Review Determination**	**Reviewer Comments**	**MCO Response and Plan of Action**
	appropriately.			
Provider Network Requirements				
6.1.2.2	The Contractor shall also be required to maintain within their network a sufficient number of Wraparound agencies and providers of specialized CSoC services including Family Support Organization(s) which provide Youth Support and Training (YST), Parent Support and Training (PST), as well as providers of Independent Living/Skills Building (ILSB) and Short Term Respite (STR).	Substantial	This requirement is partially addressed in Louisiana Coordinated System of Care: Network Development and Management Plan. The evidence addresses the requirement to include wraparound agencies, family support organizations, and providers of independent living/skills building (ILSB) and short-term respite (STR). The evidence addresses the requirement of family support organizations to provide youth support and training (YST) and parent support and training (PST). The GeoAccess report indicates an insufficient number of ILSB and STYR providers in rural areas of the state. **<u>Recommendation</u>** Magellan is aware that the plan has an issue in maintaining a sufficient number of some provider services, specifically providers of ILSB and STR in rural areas of the state. Magellan acknowledges the problem and is working to improve compliance. Its latest Geo Access Reports, outside of the review period, show an increase. Magellan should continue to devote efforts to increase the number of ILSB and STR providers in areas of the state where there is a need.	

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
6.1.15 6.1.15.1 6.1.15.2 6.1.15.3 6.1.15.4 6.1.15.5	The Contractor is not obligated to continue to contract with a provider that: .1 Does not meet the contractual standards (e.g., fails to meet all health and safety standards and maintain all required Health Standards licenses), .2 Does not meet provider qualifications and requirements as established by federal and state rules, laws and regulations, .3 Does not provide high quality services, or .4 Demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the Contractor and LDH.	Substantial	This requirement is addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 3 and page 8. The evidence is partially addressed in the Provider Utilization and Quality Profile Report, where provider utilization of services is tracked. **Recommendation** The PAHP should include the language in the standard in a policy indicating that it does not have an obligation to continue to contract with a provider that demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the contractor and LDH.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.2.4.5.1	Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206 and §440.262.	Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 12. The Network Development Plan captures the number of providers that provide sign language services, but there is no evidence that members' sign language needs are assessed and whether the number of providers who provide sign language services is sufficient. **Recommendation** The PAHP should evaluate the volume of members who require providers who can provide sign language services and evaluate whether the number is sufficient, perhaps through member services outreach to these members or via a survey.	IPRO's recommendation will be included in the Annual Network Development Plan for the next contract year.
6.2.4.6.7	Improves and increases services available for individuals with behavioral health and developmental	Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 37.	This standard will be assessed and reported in Magellan's Network Development Plan for the

Deficient 2019 Audit Elements				
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	disabilities, including autism spectrum disorders, which incorporates reducing health disparities and includes long-range fiscal planning to promote training and fiscal sustainability.		The evidence addresses the requirement of increasing services for individuals with behavioral health and developmental disabilities. The evidence does not address the specific inclusion of autism spectrum disorders. The evidence does not address long-range fiscal planning to promote training and fiscal sustainability. **Recommendation** The PAHP should include autism and fiscal planning to promote training and sustainability in the Network Develop and Management Plan. On-site, Magellan indicated that the standard will be fully reflected in the next iteration of the plan.	upcoming contract year.
6.2.4.6.8.2	Do these providers have waiting lists?	Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 5. On-site, Magellan reported that they do not have providers with waiting lists, but the follow-up documentation does not appear to have this element documented. **Recommendation** The PAHP should add this element to their provider monitoring tool.	The provider monitoring tool and tracking system will be updated to include this element. The documents will be sent to the LDH for approval by 8/31/19.
6.3.1.2 6.3.1.2.1	Scheduling/Appointment Waiting Times .1 The Contractor shall have policies and procedures for appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and	Substantial	This requirement is partially addressed in the Provider Handbook Supplement for the Louisiana Coordinated System of Care, pages 18 and 48. This requirement is partially addressed on the Magellan Healthcare website: https://www.magellanoflouisiana.com/for-	

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	procedures. The Contractor shall disseminate these appointment standard policies and procedures to its network providers and to its members and include this on website, in member and provider handbooks, in provider contracts and shall be made available to LDH for review upon request. The Contractor shall monitor compliance with appointment standards and shall have a CAP when appointment standards are not met.		providers/provider-toolkit/provider-resources/member-access-to-care/ . This requirement is partially addressed in the Network Appointment Availability Report, page 2. The requirement is partially addressed by the Accessibility of Service and Care Policy. The provider handbooks include discussion of appointment standards. The evidence did not address the requirement to include the appointment standards in the member handbook.	
6.1.17	If the Contractor declines to include individuals or groups of providers in its provider network, it must notify LDH and give the affected providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.	Minimal	Although Magellan has not declined anyone from joining in its network, it should incorporate this standard into an existing policy or develop a new one. On-site, Magellan indicated that they would incorporate the standard in a policy.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.1.21	The Contractor shall not subcontract network management, network reporting, or assurance of network sufficiency.	Minimal	Magellan indicated that it does not subcontract network management, but there was no evidence presented that indicated that they do not subcontract. The standard should be incorporated into a policy. On-site, Magellan indicated that they would incorporate the standard in a policy.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.1.23	The Contractor shall comply with network and payment requirements for members who are identified as Indians in accordance with 42 CFR §438.14.	Minimal	Although Magellan adheres to this standard, and pays according to the requirement, there was no evidence presented indicating that the standard is followed. Magellan should incorporate the language in the standard in a policy. On-site, Magellan indicated that they would incorporate the standard in a policy.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.

Deficient 2019 Audit Elements				
Contract Reference	**Contract Requirement Language**	**Review Determination**	**Reviewer Comments**	**MCO Response and Plan of Action**
6.3.1.1.1 6.3.1.1.1.1	Travel Time and Distance Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs)) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles or sixty (60) minutes, whichever is less, for one hundred percent (100%) of members.	Minimal	The evidence submitted by Magellan does not address the requirement for travel to not exceed thirty (30) miles or sixty (60) minutes for one hundred percent (100%) of members. The evidence indicates that Magellan did not assess time and distance according to the contract standards. Magellan used the standard of 60 miles (rather than the contractual 30 miles). Psychologists – standard not met. Advanced practiced registered nurses – standard not met. LCSWs – standard not met. Psychiatrists – standard not met. On-site, Magellan indicated that it is working to improve access to specialists where the standard is not met. **Recommendation** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract (30 miles or 60 minutes for 100% of the members).	The Geo Access Report template has been updated to reflect the current standards.
6.3.1.1.1.2	Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles or thirty (30) minutes, whichever is less, for one hundred percent (100%) of members.	Minimal	The evidence submitted by Magellan does not address the requirement for travel to not exceed fifteen (15) miles or thirty (30) minutes for one hundred percent (100%) of members. The evidence indicates that Magellan did not assess time and distance according to the contract standards. Magellan used the standard of 30 miles (rather than the contractual 15 miles).	The Geo Access Report template has been updated to reflect the current standards.

Deficient 2019 Audit Elements				
Contract Reference	**Contract Requirement Language**	**Review Determination**	**Reviewer Comments**	**MCO Response and Plan of Action**
			Psychologists – standard not met. Advanced practiced registered nurses – standard not met. LCSWs – standard not met. Psychiatrists – standard was met. **Recommendation** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract (30 miles or 60 minutes for 100% of the members).	
6.3.1.1.1.3	Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles or ninety (90) minutes, whichever is less, for urban members and ninety (90) miles or one hundred and twenty (120) minutes, whichever is less, for rural members. Maximum time for appointment shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent and routine care.	Minimal	This requirement is not accurately reflected in the Geo Access Reports. **Recommendation** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract requirements.	The Geo Access Report template has been updated to reflect the current standards.
Provider Services				
9.6.3.2	A description of how and under what circumstances providers are advised that they may file a complaint with the Contractor for issues that are Contractor Provider Complaints and under what circumstances a provider may file a complaint directly to LDH for those decisions that are not a unique function of the Contractor or when the provider has exhausted the Contractor's Provider Complaint	Minimal	This requirement is addressed in the provider handbook, page 32, and Comment Process Policy and Procedure. Missing from the documentation is a description of how and under what circumstances providers may file a complaint with the contractor and under what circumstances a provider may file a complaint directly to LDH. **Recommendation** The PAHP should include in policy a description	The provider handbook is currently under annual review. This recommendation will be incorporated into the version pending submission to the LDH on 9/9/19.

Deficient 2019 Audit Elements				
Contract Reference	**Contract Requirement Language**	**Review Determination**	**Reviewer Comments**	**MCO Response and Plan of Action**
	System;		of the circumstances under which a provider may file a complaint with the contractor and the circumstances under which a provider may file a complaint directly to LDH.	
9.3.2.10	Limitations on provider marketing; and	Non-compliance	This requirement is not addressed in the PAHP's website. **<u>Recommendation</u>** The PAHP should address limitations on provider marketing on the PAHP's website.	Magellan will partner with the LDH to define provider marketing limitations during our CSoC Operations Meeting on 8/22/19. The website will be updated accordingly.
Enrollment				
10.1.6	The Contractor may not disenroll CSoC members for any reason other than discharge from CSoC. Eligible recipients may choose to no longer participate in CSoC in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge. The state will disenroll effective the 1st day of a month members who lose Medicaid eligibility.	Substantial	This requirement is addressed in the Discharge from CSoC Procedure Workflow. Missing is the requirement that the contractor may not disenroll CSoC members for any reason other than discharge from CSoC. **<u>Recommendation</u>** The PAHP should include in the policy the requirement that the contractor may not disenroll CSoC members for any reason other than discharge from CSoC. During on-site discussions, the PAHP indicated that the missing language will be added to future policy.	Magellan's procedure will be updated to include IPRO's recommendation. The revision will be sent to the LDH for approval by 8/31/19.
Grievance and Appeal System				
11.3.2 11.3.2.1 11.3.2.2 11.3.2.3 11.3.2.4 11.3.2.5 11.3.2.6 11.3.2.7 11.3.2.8	Content of Notice of Adverse Benefit Determination must explain the following: 1. The adverse benefit determination the Contractor intends to take; 2. The reasons for the adverse benefit determination; 3. The member's right to request an appeal of the Contractor's adverse benefit determination; 4. The member's right to request a	Substantial	This requirement is addressed in the CSoC Inpt Clinical Denial_Full Final, page 2. **<u>File Review Results</u>** Nine (9) out of 10 appeal files reviewed were compliant. One (1) member did not receive a notice of adverse benefit determination. **<u>Recommendation</u>** The PAHP should ensure all members who have had benefits denied receive a notice of adverse benefit determination.	Magellan's non-compliant record resulted from processor error. The following will occur, by 9/30/19: A refresher training on adverse benefit determinations will be conducted. An Appeals and Grievances training module will be developed and completed by all impacted staff (and new hires, moving forward). Magellan will continue to monitor denial and appeal files to ensure accuracy

Deficient 2019 Audit Elements				
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	State Fair Hearing, after the Contractor's one level of appeal has been exhausted; 5. The procedures of exercising the rights specified in this Section; 6. The circumstances under which the expedited appeal process is available and how to request it; 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 8. Availability of interpretation services for all languages and how to access them.			and timeliness.
11.4.2.3	The process for appeals must provide the member an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the date by which the Contractor must resolve the appeal.	Substantial	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, page 4. **File Review Results** Nine (9) of 10 appeals files reviewed were compliant. One (1) of 10 appeals file reviewed was not compliant. **Recommendation** The PAHP should ensure that all members who file an appeal and whose appeal is denied receive a notice of adverse benefit determination.	Magellan's non-compliant record resulted from processor error. The following will occur, by 9/30/19: A refresher training on adverse benefit determinations will be conducted. An Appeals and Grievances training module will be developed and completed by all impacted staff (and new hires, moving forward). Magellan will continue to monitor denial and appeal files to ensure accuracy and timeliness.
11.4.2.4 11.4.2.4.1 11.4.2.4.2	Include, as parties to the appeal: • The member and his or her representative; or • The legal representative of a deceased member's estate.	Substantial	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, pages 4 to 5. **File Review Results** Eight (8) of 10 appeals files were compliant.	Magellan will revise the Notice of Action template to include a member's representative by 8/31/19. The staff will receive a training alert with the updated information, and we will

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
			Two (2) of 10 appeals files reviewed were not compliant. **Recommendation** For cases where a denial is overturned after an appeal, the PAHP should create a draft letter that includes the member's representative.	implement ongoing audits to ensure that the correct template is being utilized.
11.4.13.4.2	The right to request to receive benefits while the hearing is pending, and how to make the request; and	Minimal	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and CSoC Appeal Full Clinical Denial_Final. **Recommendation** The PAHP should clearly inform the member in the appeals resolution notice that the member has the right to request to receive benefits while the state fair hearing is pending, and to provide information on how to make this request. **Final Review Determination** No change in determination. This item is found in CFR 438.408 Resolution and notification: Grievances and appeals, (e) Content of notice of appeal resolution. The written notice of the resolution must include the following: (ii)The right to request and receive benefits while the hearing is pending, and how to make the request.	We respectfully disagree with your review determination. Magellan has been utilizing the current Notice of Action template, based on guidance from the LDH. We will discuss IPRO's recommendations during our meeting with them on 8/22/19.
11.4.13.4.3	That the member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action.	Non-compliance	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6. Also addressed in file review. Zero (0) of 7 appeals files reviewed were compliant. Seven (7) of 7 appeals files reviewed were not compliant.	We respectfully disagree with your review determination. Magellan has been utilizing the current Notice of Action template, based on guidance from the LDH. We will discuss IPRO's recommendations during our meeting with them on 8/22/19.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
			Recommendation The PAHP should communicate in writing to the member that they may be held liable for the cost of those benefits if the state fair hearing decision upholds the contractor's action. **Final Review Determination** No change in determination. This item is found in CFR 438.408 Resolution and notification: Grievances and appeals, (e) Content of notice of appeal resolution. The written notice of the resolution must include the following: (iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PAHP's, or PAHP's adverse benefit determination.	
Quality Management				
12.2.3.2.6	Describe how the Contractor will collect data on race, ethnicity, gender, age, primary language, and geography and ensure said data is accurate.	Substantial	This requirement is partially addressed in the QAPI Work Plan, pages 12 and 14. There is no reference to how the accuracy of demographic data will be assessed. The Data Collection and Integration Procedure describes how the integrity and accuracy of the data is maintained. **Recommendation** The PAHP should revise its QAPI Work Plan to reference the Data Collection and Integration Procedure and/or include a description of how demographic data will be assessed for accuracy.	Magellan will update the Work Plan as recommended. The updated QAPI Work Plan will be reviewed/approved during the September, 2019 Louisiana CSoC Quality Improvement Committee (QIC). QIC minutes and documentation are submitted to the LDH within 5 business days of every meeting and, therefore, they will have the updated Work Plan for their records.
Program Integrity				
13.1.1.15 13.1.1.15.1 13.1.1.15.2 13.1.1.15.3	The Contractor shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless	Substantial	This requirement is addressed in PI 145 report. Missing from documentation are the requirements that: 1. Contract the subject …	Magellan's FWA policy will be updated to reflect IPRO's recommendation by 8/31/19.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	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 Contractor shall not take any of the following actions as they specifically relate to Medicaid claims: 1. Contact the subject of the investigation about any matters related to the investigation; 2. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or 3. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.		2. Enter into or attempt … 3. Accept any monetary… " **Recommendation** The PAHP should include discussion of the following in written policy: "The Contractor shall not take any of the following actions as they specifically relate to Medicaid claims: 1. Contract the subject … 2. Enter into or attempt … 3. Accept any monetary… "	
13.5.1	In accordance with 42 CFR §455.1(a)(1) and §455.17, the Contractor shall be responsible for promptly reporting suspected fraud, waste, and abuse information to the Louisiana 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). Additionally, the Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor, an Contractor employee, or network providers or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C.	Substantial	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards on page 16. Missing is reference to the time frame (3 days) for reporting suspected fraud, waste, and abuse to the Louisiana Office of Attorney General, MFCU, and LDH. **Recommendation** The PAHP should include in policy which agencies and the time frame, for reporting suspected fraud, waste, and abuse.	Magellan's Program Integrity & Compliance Program policy will be updated to reflect IPRO's recommendation by 8/31/19.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	§1320a-7) or any Contractor which could result in exclusion, debarment, or suspension of the Contractor or a Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.			
13.1.2.4	The Contractor shall establish policies and procedures for referral of suspected Fraud, Waste and Abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process will be developed to expedite information for appropriate disposition.	Minimal	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 16, and in the 145 Report template. Missing from the documentation is a standardized referral process. **Recommendation** The PAHP should develop policies and a standardized procedure for referral of suspected Fraud, Waste, and Abuse to LDH.	Although Magellan's Program Integrity Referral Form is currently used to report suspected FWA, our Program Integrity & Compliance policy will be updated to reflect IPRO's recommendation by 8/31/19. A workflow will be created to illustrate the process, as well.
13.2.1	As required in 42 CFR §455.104(a), the Contractor shall provide LDH with full and complete information on the identity of each person or corporation with an ownership interest of five percent (5%) or greater in the Contractor, or any subcontractor in which the Contractor has five percent (5%) or more ownership interest. The Contractor shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of five percent (5%) or greater in the Contractor and any of its subcontractors, including all entities owned or controlled by a parent organization. This information shall be provided to LDH on the LDH approved Contractor Disclosure Form within thirty (30) days of DOA/OSP	Minimal	This requirement is addressed in the Conflicts of Interest Policy and Standards, page 7. However the documents provided do not address reporting ownership interest to LDH within 30 days. **Recommendation** The PAHP should incorporate contractual requirement to report ownership interest to LDH within 30 days into policy.	Magellan's Conflict of Interest policy will be updated to reflect IPRO's recommendation by 8/31/19.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	approval of the signed contract and whenever changes in ownership occur.			
13.4.2	The Contractor is responsible for the return to the State of any payments made for services rendered by an excluded provider.	Minimal	This requirement is addressed in the Administration of Claims Overpayment Recovery Policy and Standards and Medicaid: Program Integrity and Compliance Program, page 25. Missing from the documentation provided is the requirement that the contractor is responsible for the return to the state of any payments made for services rendered by an excluded provider. **Recommendation** The PAHP should include in policy that the contractor is responsible for the return to the state of any payments made for services rendered by an excluded provider.	Magellan's Administration of Claims Overpayment Recovery policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.5.8 13.5.8.1 13.5.8.2 13.5.8.3	The Contractor is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria: .1 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 .2 The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or .3 When the issues, services or	Minimal	This requirement is addressed in Administration of Claims Overpayment Recovery. Missing is discussion of sections .1, .2, and .3. **Recommendation** The PAHP should include subsections .1, .2, and .3 in policy documents.	Magellan's Administration of Claims Overpayment Recovery policy will be updated to reflect IPRO's recommendation by 8/31/19.

Deficient 2019 Audit Elements				
Contract Reference	Contract Requirement Language	Review Determination	Reviewer Comments	MCO Response and Plan of Action
	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.			
13.6.5	Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the Contractor has identified and submitted a referral of fraud to the Department, MFCU or other appropriate law enforcement agency, unless approved by LDH.	Minimal	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards. Missing is the requirement that contact with a provider shall be prohibited in instances resulting from suspected fraud. This was also discussed during the on-site visit. **Recommendation** The PAHP should include in policy the requirement that contact with a provider shall be prohibited in instances resulting from suspected fraud.	Magellan's Program Integrity and Compliance policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.6.3	All reviews must be completed within one hundred and eighty (180) 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.	Non-compliance	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards. Missing is the requirement that all reviews must be completed within 180 days. **Recommendation** The PAHP should include in policy the requirement that all reviews must be completed within 180 days of the date the case was opened unless an extension is authorized by LDH.	Magellan's SIU and Program Integrity and Compliance policies will be updated to reflect IPRO's recommendation by 8/31/19.

PAHP Final Audit Tools

Ten (10) 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.

Member Services

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.	**MEMBER SERVICES**					
5.1	**General Requirements**					
5.1.1	As outlined under the 1915(b) waiver, the State permits indirect marketing by the Contractor. Indirect marketing activities are marketing activities that exclude the use of targeting and segmentation practices. The Contractor is allowed to attend health fairs, sponsor community forums, radio spots, print media, etc. and provide general outreach, so long as the entity does not target its materials directly to Medicaid beneficiaries. The Contractor and its subcontractors shall be permitted to perform the following activities:					
5.1.1.2	Attend or organize activities that benefit the entire community such as health fairs or other health education and promotion activities. Notification to LDH must be made of the activity and details must be provided about the planned outreach activities at least ten (10) business days prior to any event.					
5.1.2	Member education, which differs from marketing, is defined as communication with an enrolled member of the Contractor to retain the member and improve the health status of enrolled members. All member education materials and					

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	activities shall comply with the requirements of 42 CFR §438.10, §438.104, and the LDH requirements set forth in this contract.					
5.1.8	The Contractor shall comply with the Office of Minority Health, Department of Health and Human Services' "Cultural and Linguistically Appropriate Services Standards" and 42 CFR §440.262. Information may be found at the following url: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 and participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members.					
5.1.11 5.1.11.1 5.1.11.2 5.1.11.3	The Contractor shall include in all materials the following: 1. The date of issue; 2. The date of revision; and/or 3. If prior versions are obsolete.					
5.1.13	The Contractor, any subcontractor or providers are not allowed to steer members to providers or a specific Integrated Medicaid Managed Care Plan. LDH retains the discretion to deny the use of marketing and member education material that it deems to promote undue member/patient steering.					
5.2	**Marketing and Educational Materials Approval Process**					
5.2.1	The Contractor must obtain prior written approval from LDH for marketing, informational, and educational materials at least thirty (30) days prior to distribution unless previously approved by LDH. This includes, but is not limited to, print, television and radio advertisements; member handbooks,					

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	identification cards and provider directories; Contractor website screen shots; promotional items; brochures; letters and mass mailings and e-mailings. Neither the Contractor nor its subcontractors may distribute any Contractor materials without LDH consent.					
5.3	**Review Process for Materials**					
5.3.3	LDH reserves the right to require the Contractor to discontinue or modify any marketing or education materials after approval.					
5.3.4	The Contractor must review all marketing and member education materials on an annual basis and revise materials, if necessary, to reflect current practices. Any revisions must be approved by LDH prior to distribution.	Evidence of review and if applicable LDH approval		Full	The PAHP provided evidence that member education and marketing materials were sent to LDH prior to distribution. LDH was sent emails in October 2018 advising that the PAHP had attached member materials for LDH's review and approval prior to distribution.	
5.4	**Review Process for Events and Activities**					
5.5	**Member Education Plan**					
5.5.1	The Contractor shall develop and implement a plan detailing the member education activities it will undertake and materials it will create during the contract period. The detailed plan must be submitted to LDH for review within thirty (30) calendar days from the date the contract is approved by DOA/OSP.	P/P for Member Education Materials Example of written education materials Example of LDH approval		Full	This requirement is partially addressed in the Examples of LDH Approvals documentation. The PAHP also submitted the Member Education Plan as evidence of compliance with this requirement.	
5.5.2	A summary report of all member education efforts for the year must be submitted to LDH within thirty (30) days of the end of the calendar year.	Annual Summary Report of Member Education Efforts		Full	This requirement is addressed in the Member Education Plan Narrative and in the Member Education Calendar.	
5.5.3	The Contractor shall not begin member education activities prior to approval by LDH.	P/P for Member Education Materials		Full	This requirement is addressed in the Member Education Plan Narrative.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.5.4 5.5.4.1 5.5.4.2 5.5.4.3 5.5.4.4 5.5.4.5 5.5.4.6 5.5.4.7 5.5.4.8 5.5.4.9	The Contractor shall take into consideration projected enrollment levels for equitable coverage of the state. Informational materials shall be distributed to its entire membership, unless otherwise approved by LDH. The plan shall include, but is not limited to: 1. Stated member education goals and strategies; 2. The Contractor's plans for new member outreach and orientation; 3. Details of proposed marketing and member education activities and events; 4. A member education calendar, which begins with the date the signed contract, between LDH and the Contractor, is approved by DOA/OSP: website development, printed materials, material distribution plans (including specific locations), outreach activities (health fairs, area events, etc.); 5. Distribution methods and schedules for all materials, including media schedules for electronic or print advertising (include date and station or publication); 6. How the Contractor plans to meet the informational needs, relative to member education, for the physical and cultural diversity of the service area. This may include, but is not limited to: how the Contractor will meet the health literacy needs of membership and a description of provisions for non-English speaking individuals, language interpreter services, alternate communication mechanisms (such as sign language, braille, audio tapes); 7. A list of all subcontractors engaged in marketing or member education activities for	P/P for Written Member Materials Guidelines Example of informational materials Education Calendars Distribution Schedules P/P re: Cultural Competency in Written Member Materials P/P re: Subcontracting for Marketing Materials		Full	This requirement is addressed in the Member Education Plan Narrative.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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 Contractor; 8. The Contractor's plans to monitor and enforce compliance with all marketing and member education guidelines among internal staff and subcontractors; and 9. Copies of all marketing and member education materials (print and multimedia) the Contractor or any of its subcontractor's plans to distribute that are directed at potential eligible members.					
5.5.5	Any changes to the member education plan or included materials or activities must be submitted to LDH for approval at least thirty (30) days before the marketing or member education activity, unless the Contractor can demonstrate just cause for an abbreviated timeframe.	P/P for Written Member Materials Guidelines Example of changes to materials		Full	Approval was confirmed on-site by LDH staff.	
5.6	**Written Materials Guidelines**					
5.6.1	The Contractor must comply with the following requirements as they relate to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):					
5.6.1.1 5.6.1.1.1 5.6.1.1.2 5.6.1.1.3 5.6.1.1.4 5.6.1.1.5 5.6.1.1.6	All member materials must be in a style and reading level that will accommodate the reading skills of members. In general the writing should be at no higher than a fifth 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 ensure accuracy: 1. Flesch – Kincaid; 2. Fry Readability Index; 3. PROSE The Readability Analyst (software developed by Educational Activities, Inc.); 4. Gunning FOG Index;	P/P for Written Member Materials Guidelines Member Handbook Evidence that written materials have been tested against the reading level standard		Full	This requirement is addressed in the Member Education Plan Narrative.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	5. McLaughlin SMOG Index; or 6. Other computer generated readability indices accepted by LDH.					
5.6.1.2	LDH reserves the right to require evidence that member education materials have been tested against the fifth grade reading-level standard.					
5.6.1.3	All written materials must be clearly legible with a minimum font size of twelve-point, unless otherwise approved by LDH or required by 42 CFR §438.10.	P/P for Written Member Materials Guidelines Example of written member materials		Full	This requirement is addressed in the Medicaid: Enrollee Communication and Information Requirements Policy. The submitted member materials are all clearly legible with a minimum font size of 12-point.	
5.6.1.4	All written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services.	P/P for Written Member Materials Guidelines Example of written member materials		Full	The Member Education Plan Narrative addresses language interpreter services and how to access these services. On-site review demonstrated that the PAHP's website includes the requirement that the oral interpretation is performed in real time and is at no expense to the members.	
5.6.1.5	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	P/P for Communication Alternatives		Substantial	This requirement was addressed via the on-site walkthrough of the website. Language regarding communication alternatives was observed. However, there was no evidence that the alternative forms of communication are provided at no expense to the member. **Recommendations** The PAHP should add language on its member portal that alternative forms of communication, reflecting the needs of members with the disabilities indicated in	Our Member Handbook has been updated to include additional information regarding free services and alternate forms of communication for Members with disabilities. Once approved by the LDH, this information will be included on our website, as well.

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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 regulation, are provided at no expense to the member.	
5.6.1.6	All marketing activities should provide for equitable distribution of materials without bias toward or against any group.	P/P for Written Member Materials Guidelines		Full	This requirement is addressed in the Nondiscrimination and Language Access Policy.	
5.7	**MEMBER WEBSITE**					
5.7.1	The Contractor shall develop and maintain a customized website that provides online access to member service information. Prior written approval from LDH is required for all content appearing on the website. Web content shall be written in easily understood language at or below a fifth-grade reading level and shall follow the written materials guidance in this section.	P/P for Written Member Materials Guidelines Evidence that written materials have been tested against the reading level standard Example of LDH approval Review of website		Full	The PAHP's website provides online access to member services information. The 5th-grade reading level requirement is addressed in the Member Education Plan Narrative.	
5.7.1.2	The Contractor must remain compliant with HIPAA privacy and security requirements when providing member eligibility or member identification information on the website.	P/P for Written Member Materials Guidelines P/P for HIPAA Compliance		Full	This requirement is addressed in the Member Education Plan Narrative.	
5.7.1.3	The Contractor website should, at a minimum, be in compliance with Section 508 of the Americans with Disabilities Act, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern. The Contractor website must follow all written materials guidelines included in this section.	P/P for Written Member Materials Guidelines Demonstration of machine readability		Full	This requirement is addressed in the Web Content Accessibility Guidelines (WCAG) Policy.	
5.7.1.4	Use of proprietary items that would require a specific browser is not allowed.	P/P for Written Member Materials Guidelines		Full	This requirement is addressed in the Web Content Accessibility Guidelines (WCAG) Policy. Several browsers were tried and confirmed ability to access the PAHP's website.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.7.1.5	Forms on which members may file grievances, appeals, change in contact or address, feedback or recommendations to the Contractor shall be available and must be provided upon request of the member. The Contractor shall make all forms easily available on the Contractor's website.	Review of website		Full	This requirement was addressed in the on-site walkthrough of the website, where the required forms are available.	
5.7.1.6 5.7.1.6.1 5.7.1.6.2 5.7.1.6.3 5.7.1.6.4 5.7.1.6.5 5.7.1.6.6 5.7.1.6.7 5.7.1.6.8 5.7.1.6.9 5.7.1.6.10 5.7.1.6.11 5.7.1.6.12 5.7.1.6.13 5.7.1.6.14 5.7.1.6.15 5.7.1.6.16 5.7.1.6.17 5.7.1.6.18	The Contractor must provide the following information on its website, and such information shall be easy to find, navigate, and understand by all members: 1. The most recent version of the member handbook; 2. Corporate and local telephone, mailing address and email contact information, including a toll-free customer service number prominently displayed and a Telecommunications Device for the Deaf (TDD) number, with hours of operation; 3. A searchable list of network providers shall be updated in near real time, but at a minimum weekly, upon changes to the network; 4. Links to the LDH and CSoC websites; 5. The capability for members to submit questions and comments to the Contractor and receive responses; 6. Member eligibility information; 7. Information on how to access behavioral health services; 8. Explanation of available services; 9. Crisis response information and toll-free crisis telephone numbers; 10. General customer service information; 11. Information on how to file grievances and appeals; 12. Updates on emergency situations that may	P/P for Written Member Materials Guidelines Review of website		Full	This requirement was addressed in the on-site walkthrough of the website, where the required information was discussed.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	impact the public, such as natural and human-caused disasters that would require time sensitive action by members, such as evacuation from their homes or communities or other preparedness-related activities. The website shall include hyperlinks to state and federal emergency preparedness websites; 13. Holistic health information and related links to health and wellness promotion articles and websites; 14. Information regarding community forums, volunteer activities, and workgroups/committees that provide opportunities for members receiving services, their families/caregivers, providers, and stakeholders to become involved; 15. Information regarding advocacy organizations, including how members and other families/caregivers may access advocacy services; 16. Instructions on how to report suspected member or provider fraud and abuse; 17. Website address with direct links for the Integrated Medicaid Managed Care plan(s); and 18. Any other documents as required by LDH.					
5.8	**Member Communication/Education Required Materials and Services**					
5.8.1	The Contractor shall ensure all materials and services do not discriminate against Contractor members on the basis of their health history, health status or need, healthcare services, and any educational limitation (e.g., illiteracy). This applies to enrollment, materials and processes from the Contractor.	P/P for Written Member Materials Guidelines P/P for Anti-Discrimination		Full	This requirement is addressed in the Nondiscrimination and Language Access Policy.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.8.2	New Member Orientation					
5.8.2.1 5.8.2.1.1 5.8.2.1.2 5.8.2.1.3 5.8.2.1.4 5.8.2.1.5 5.8.2.1.6	The Contractor shall have written policies and procedures to orient new members on the following, but not limited to: 1. What benefits and services are available; 2. How to utilize services; 3. What to do in an emergency or urgent medical situation; 4. How to report program integrity issues; 5. How to report critical incidents; and 6. How to a file a grievance and appeal.	P/P for Written Member Materials Guidelines P/P for new member orientation Example of orientation documents		Full	The Member Education Plan Narrative discusses new member outreach and orientation. The requirements are addressed in the member handbook.	
5.8.2.2	The Contractor shall submit a copy of the procedures to be used to contact members for initial member education in the Member Education Plan.	P/P for new member orientation		Full	This requirement is addressed in the Marketing Activities Policy.	
5.8.3 5.8.3.1 5.8.3.2 5.8.3.3	Welcome Letter 1. The welcome letter and member handbook shall be distributed to all new CSoC families through the WAAs by hard copy at the first face-to-face WAA/family meeting. A current, accurate hard copy provider directory will be provided to members upon request. This information shall also be available electronically through the website and comply with 42 CFR §438.10(c). 2. The welcome letter and member handbook will be utilized by the Contractor throughout the contract and during periods of transition if mandated by LDH. 3. The Contractor shall adhere to the requirements for the member handbook and Provider Directory as specified in this contract, its attachments/appendices, and in accordance with 42 CFR §438.10.	P/P for Welcome Letter Example of Welcome Letter Member Handbook		Full	This requirement is addressed in the Member Education Plan Narrative.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.8.4	Additional Member Educational Materials and Programs					
5.8.4.1 5.8.4.1.1 5.8.4.1.2 5.8.4.1.3 5.8.4.1.4 5.8.4.1.5	The Contractor shall prepare and distribute educational materials, including, but not limited to, the following: 6. Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to providers and other information that is helpful to members; 7. Literature, including brochures and posters, such as calendars, regarding all health or wellness promotion programs offered by the Contractor. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders; 8. Identify and educate members who access the system inappropriately and provide continuing education as needed. 9. Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date in accordance with 42 CFR §438.10(g); and 10. All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P for distribution of written member materials		Substantial	This requirement is addressed in the Member Education Plan Narrative. The PAHP does not have evidence of such educational materials as brochures, posters, calendars, or EDSTD Outreach materials. Member Services handles members who access the system inappropriately. **Recommendations** The PAHP should consider some form of ongoing education of its members, for example, devoting a section of its website to presenting monthly tips, highlighting healthy practices. The PAHP should consider adding a calendar to the website, including reminders for routine services (e.g., flu shots, vaccinations, EPSTD services). The PAHP should include language on the website to educate members about how to use and access the website appropriately – for example a "do's and don'ts" section.	Magellan's quarterly Member Newsletter is available on our website*. Our Fall and Winter editions will feature the topics IPRO recommended, including: • tips on navigating the website • EPSDT and mental health information • health plan-related information (e.g., contact information) • seasonal health items (e.g., flu shot reminder) * Wraparound Facilitators also share hard copy versions with Members.
5.9	**Member Handbook**					
5.9.2	At a minimum, the Member Handbook shall include information required in 42 CFR §438.10(g)(2) and the following information:	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.1	Table of contents;	Member Handbook		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.9.2.2	A general description about how the Contractor operates, member rights and responsibilities, and appropriate utilization of services;	Member Handbook P/P for Members' Rights and Responsibilities		Full	This requirement is addressed in the member handbook.	
5.9.2.3	CSoC eligibility requirements;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.4	Member's right to change providers within the Contractor (and how to);	Member Handbook Example of material informing members of their right to change providers		Full	This requirement is addressed in the member handbook.	
5.9.2.5	The member's freedom of choice among Contractor providers and services and any restrictions;	Member Handbook Example of material informing members of their freedom of choice		Full	This requirement is addressed in the member handbook.	
5.9.2.6	Member's rights and responsibilities, as specified in 42 CFR §438.100;	Member Handbook P/P for Members' Rights and Responsibilities		Full	This requirement is addressed in the member handbook.	
5.9.2.7	Member's Bill of Rights	Member Handbook P/P for Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.9.2.8	Information regarding the member call center;	Member Handbook Example of materials informing members of the member call center		Full	This requirement is addressed in the member handbook and in the CSoC Member Services Call Workflows.	
5.9.2.9	Information on how to report member or provider Fraud, Waste, and Abuse;	Member Handbook P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the member handbook.	
5.9.2.10	The amount, duration, and scope of benefits available to the member under the contract between the Contractor and LDH in sufficient detail to ensure that members understand the benefits to which they are entitled;	Member Handbook Example of this communication		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.9.2.11	Procedures for obtaining benefits, including plan of care development and prior authorization requirements;	Member Handbook P/P re: obtaining benefits		Full	This requirement is addressed in the member handbook.	
5.9.2.12	Where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;	Member Handbook Example of this communication Onsite Review of website		Full	This requirement is addressed in the Member Rights and Responsibilities section on the website.	
5.9.2.13	Where and how to access behavioral health services, provider information (including emergency or crisis services), and a description of covered behavioral health services;	Member Handbook Access report		Full	This requirement is addressed in the member handbook.	
5.9.2.14 5.9.2.14.1 5.9.2.14.2 5.9.2.14.3 5.9.2.14.4 5.9.2.14.5	The extent to which, and how, after-hours and emergency coverage are provided, including: 1. What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); 2. That prior authorization is not required for emergency services; 3. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; 4. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the Contractor; and 5. That, subject to the provisions of 42 CFR Part 438 specific to emergency services, especially §438.114, which the Contractor shall summarize in the member handbook, the member has a right to use any hospital or other setting for emergency care.	Member Handbook Example of this communication		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.9.2.15	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.	
5.9.2.16	That the member has the right to refuse to undergo any medical service or treatment or to refuse to accept any health service provided by the Contractor if the member objects (or in the case of a child, if the parent or guardian objects) on religious grounds;	Member Handbook P/P for Members' Rights and Responsibilities		Full	This requirement is addressed in the member handbook.	
5.9.2.17	For counseling or referral services that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. The state shall provide information on how and where to obtain the service;	Example of this communication if applicable		Full	The PAHP covers all services.	
5.9.2.18 5.9.2.18.1 5.9.2.18.2 5.9.2.18.3 5.9.2.18.4	Grievance, appeal and fair hearing procedures that include the following: 1. The right to file grievances and appeals; 2. The requirements and timeframes for filing a grievance or appeal; 3. The availability of assistance in the filing process; 4. The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Member Handbook P/P for Grievances and Appeals		Full	This requirement is addressed in the member handbook.	
5.9.2.18.5 5.9.2.18.5.1 5.9.2.18.5.2 5.9.2.18.5.3	The fact that, when requested by the member: 1. Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and 2. 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. 3. In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of LDH who	Member Handbook P/P for continuation of member benefits P/P for State Fair Hearings		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	has final authority to determine whether services must be provided as per LAC 50:I.3717.C.					
5.9.2.18.6 5.9.2.18.6.1 5.9.2.18.6.2 5.9.2.18.6.3	For State Fair Hearing: 1. The right to a hearing; 2. The method for obtaining a hearing; and 3. The rules that govern representation at the hearing.	Member Handbook P/P for State Fair Hearings		Full	This requirement is addressed in the member handbook.	
5.9.2.19 5.9.2.19.1 5.9.2.19.2 5.9.2.19.3 5.9.2.19.4	A description of advance directives which shall include: 1. The member's rights under state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the Member Handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; 2. Information that members can file grievances about the failure to comply with an advance directive with the LDH Health Standards Section; 3. Information about where a member can seek assistance in executing an advance directive and to whom copies should be given; and 4. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.	Member Handbook Example of this communication P/P for Members' Rights and Responsibilities P/P for filing of grievances and appeals		Full	This requirement is addressed in the member handbook.	
5.9.2.20	How to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a "no-show";	Member Handbook Example of this communication		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.9.2.21	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.	
5.9.2.22	Family's/caregiver's or legal guardian's role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.23	Generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult's engagement, resilience, strength-based and evidence-based practice, and best/proven practices;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.24	Information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.25	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;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.26	How to identify and contact the WAAs and FSO;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.27	How to obtain emergency and non-emergency medical transportation;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.28	Information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.29	Instructions on how to request multi-lingual interpretation (oral) and written translation when needed at no cost to the member in accordance	Member Handbook		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	with Section 5.15. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;					
5.9.2.30	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;	Member Handbook Provider Directory		Full	This requirement is addressed in the member handbook.	
5.9.2.31	Information on the member's right to a second opinion at no cost and how to obtain it;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.32	Any additional text provided to the Contractor by LDH or deemed essential by the Contractor;	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed in the member handbook. The date of the last revision was September 2018.	
5.9.2.34	The mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.2.35 5.9.2.35.1. 5.9.2.35.2 5.9.2.35.3 5.9.2.35.4	Additional information that is available upon request, including the following: 1. Information on the structure and operation of the Contractor; 2. Pharmacy location or medication information availability; 3. Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and 4. Service utilization policies.	Member Handbook		Full	This requirement is addressed in the member handbook.	
5.9.3	The Contractor shall review the member handbook at least annually by contract year. If the	Distribution information		Full	The member handbook is updated on an ongoing basis on the website and the	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	Contractor makes changes to the Member Handbook, at a time other than the annual update, the Contractor shall notify members of the revisions on a timely basis. Documentation of the handbook's distribution shall be included in the care management record. Updated hard copies will be provided to members upon request.				Deliverables grid is updated and submitted to the LDH when changes are made.	
5.9.4	The Contractor shall provide members or their families/caregivers receiving services with written notice of significant changes related to member rights, advance directives, grievances, reconsiderations or state fair hearings at least thirty (30) days in advance of the intended effective date.	P/P for Written Member Materials Guidelines		Full	This requirement is addressed in the member handbook.	
5.10	**Provider Directory for Members**					
5.10.1	The Contractor shall develop and maintain a Provider Directory in a web-based, searchable, machine readable online directory for members and the public in compliance with 42 CFR §438.10(h). The directory shall be made available to members in paper form upon their request.	P/P for Provider Directory distribution review of website		Full	The provider directory is available to all members upon request and is accessible and searchable via the PAHP's website. In follow-up, the PAHP stated that the information in the directory can be manipulated (text vs. imaging).	
5.10.3	The hard copy directory for members shall be updated at least monthly. The web-based online version shall be updated in near real time, however no less than weekly. The electronic version shall be updated prior to each submission to the Medicaid Fiscal Intermediary. While daily updates are preferred, the Contractor shall at a minimum submit no less than weekly.	P/P for updates to Provider Directory		Full	This requirement is addressed in the Network Provider Data Maintenance and Data Integrity Policy.	
5.10.4 5.10.4.1 5.10.4.2 5.10.4.3	In accordance with 42 CFR §438.10(h), the Provider Directory shall include, but not be limited to: .1 Names, including any group affiliation, street	P/P for Provider Directory Provider Directory documents		Full	This requirement is addressed in the Network Provider Data Maintenance and Data Integrity Policy and in the provider directory.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.10.4.4 5.10.4.5 5.10.4.6	address, locations, telephone numbers, website URL if applicable, and non-English languages spoken by current contracted providers, including whether the provider and/or hospital is accepting new 0Medicaid patients; .2 Indication of populations served by the provider (e.g., age range of clients) and specialties; .3 Whether the providers office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment; .4 Identification of any restrictions on the member's freedom of choice among providers; .5 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); and .6 Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.					
5.11	**Member Service and Call Center Staff**					
5.11.1	Call center staff provide the single point of entry for all individuals that seek information about the Contractor's services. This includes members or others calling on behalf of members. Call center staff obtain demographic information and emergency contact information from members and their families/caretakers; gather insurance information, including Medicaid eligibility; and assist callers in accessing information on member rights and benefits, obtaining services, and filing					

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	grievances. The call center staff determines the reason for the call and transfers the call to the appropriate party within the Contractor's operations or provides contact information. For members seeking services or information related to their services or plan of care, the call center staff will transfer the call to a Care Manager.					
5.11.2	Member services representatives must be trained in the geography of Louisiana as well as culture and correct pronunciation of cities, towns, and surnames.	Example of applicable trainings with sign-in sheets		Full	This requirement is addressed in the Telephonic Customer Service Clinical Quality Monitoring Policy and in the Member Services Scope of Work Job Functions.	
5.11.3 5.11.3.1 5.11.3.1.1 5.11.3.1.2 5.11.3.1.3 5.11.3.1.4 5.11.3.1.5 5.11.3.1.6 5.11.3.1.7	The Contractor's member services department shall operate as the common single point of entry for all services and perform the following functions: .1 The Contractor shall maintain a toll-free member service call center, physically located in Louisiana, with dedicated staff to respond to member questions including, but not limited to such topics as: .2 Explanation of Contractor policies and procedures; .3 Prior authorizations; .4 Access information; .5 Information on specialists; .6 Referrals to Integrated Medicaid Managed Care Program Plans; .7 Resolution of service and/or service delivery problems; and .8 Member grievances and appeals.	P/P for Member Services Department P/P for maintenance of toll-free call center P/P for training of call center staff Example materials of applicable call center staff training with sign-in sheets		Full	This requirement is addressed in the Telephonic Customer Service Clinical Quality Monitoring Policy and in the Member Services Scope of Work Job Functions.	
5.11.4	The toll-free number must be staffed twenty-four (24) hours per day, seven (7) days per week for crisis response and service authorization by care managers.	P/P for answering of member line		Full	This requirement is addressed in the Telephonic Customer Service Clinical Quality Monitoring Policy, the Accessibility of Service and Care, and in the Member Services Scope	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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 Work Job Functions.	
5.11.5	The member line shall be answered by a live voice at all times.	P/P for answering of member line		Full	This requirement is addressed in the Member Service Scope of Work Job Functions and in the Member Services Telephone Line and Standards Policy.	
5.11.6	There shall be twenty-four (24) hour access to an LMHP and board certified psychiatrist as required to provide clinical consultation.	P/P for access to LMHP and psychiatrist as required		Full	This requirement is addressed in the Accessibility of Service and Care Policy.	
5.11.7	The Contractor shall have sufficient telephone lines and staff available to answer incoming calls. LDH reserves the right to specify staffing ratio and/or other requirements if it is determined that the call center staffing/processes are not sufficient to meet member needs as verified by LDH through call management metrics, member surveys, unplanned call center assessments, or Contractor independent evaluation methods.					
5.11.8	The Contractor must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain required call center access standards. The Contractor must develop and implement a plan to sustain call center performance in situations where there is high call/email volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations (including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.	P/P for contingency plans		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy.	
5.11.9	The Contractor must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with	P/P for help line addressing staffing, personnel, hours of operation, access and response standards, monitoring of calls via		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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. The Contractor shall submit any new telephone help line policies and procedures to LDH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The Contractor call center must have the capability to produce an electronic record to document a synopsis of all calls.	recording or other means, and compliance with standards Example of LDH communication if applicable Example of synopsis				
5.11.10	The Contractor shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The Contractor shall submit call center quality criteria and protocols to LDH for review upon request. The Contractor shall provide a member service approach that ensures working with all parties involved with the member to establish program eligibility. The Contractor shall interact with callers in a courteous, respectful, polite, culturally responsive, and engaging manner. The Contractor shall provide to LDH upon request copies of the member call center script and any screening, evaluation, and assessment tool used in coordinating any caller's care or needs.	Call Center metrics reports		Full	This requirement is addressed in the Quality Monitoring Policy, the Quality Observation Form, and in the Quality Evaluation Reports per month.	
5.11.16	The Contractor shall refer reconsiderations, appeals and Quality of Care issues to Contractor's care manager or other designated staff to handle.	P/P for referral of reconsiderations, appeals and Quality of Care issues		Full	This requirement is addressed in the Comments Policy.	
5.11.17	The Contractor's call abandonment rate shall not exceed five percent (5%) monthly.	Call Center Metrics report		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy and in the LA CSoC Call Reporting documentation.	
5.11.18	The call center shall utilize a language line translation system for callers whose primary language is not English. Assistance should include,	P/P for language translation		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy and in the Voiance Desktop	

Member Services						
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	but not be limited to, use of qualified peer support for this service. This service shall be available twenty-four (24) hours a day, seven (7) days a week, and three hundred and sixty-five (365) days a year.				Reference.	
5.11.19	The Contractor shall have available, at all times, a Telecommunications Device for the Deaf (TDD) and/or relay systems.	P/P for TDD or relay system		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy.	
5.11.21	The Contractor shall ensure the toll-free number is publicized throughout Louisiana. All costs of publication shall be paid by the Contractor.	Member Handbook Member website		Full	This requirement is addressed by the toll-free number on the PAHP's website.	
5.11.22	The Contractor shall assist and triage callers who may be in crisis by effectuating an immediate transfer to a care manager. The call shall be answered by the care manager within sixty (60) seconds and only transferred via a warm line to a care manager. The Contractor shall respect the caller's privacy during all communications and calls.	P/P for transfer to CM Call center script		Full	This requirement is addressed in the LA CSoC General Call Scripts.	
5.12	**Automated Call Distribution (ACD) System**					
5.12.1	The Contractor shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:	P/P for ACD		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy.	
5.12.1.1	Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	P/P for call management		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy and in the Member Service Scope of Work Job Functions.	
5.12.1.2	Transfer calls to other telephone lines;	P/P for call transfers		Full	This requirement is addressed in the Member Service Scope of Work Job Functions and in the LA CSoC General Call Scripts.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.12.1.3	Provide detailed analysis as required for the reporting requirements including but not limited to: the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred, hold time, abandonment rate, wait time, busy rate, response time, and call volume;			Full	This requirement is addressed in the LA CSoC Call Reporting documentation.	
5.12.1.4	Provide a message that notifies callers that the call may be monitored for quality control purposes;	ACD script		Full	This requirement is addressed in the LA CSoC Toll Free Routing documentation.	
5.12.1.5	Measure the number of calls in the queue at all times, particularly peak times;	Call Center Metrics		Full	This requirement is addressed in the LA CSoC Call Reporting documentation.	
5.12.1.6	Measure the length of time callers are on hold;	Call Center Metrics		Full	This requirement is addressed in the Avaya Call Metrics Report.	
5.12.1.7	Measure the total number of calls and average calls handled per day/week/month;	Call Center Metrics		Full	This requirement is addressed in the LA CSoC Call Reporting documentation.	
5.12.1.8	Measure the average hours of use per day;	Call Center Metrics		Full	This requirement is addressed in the Avaya Call Metrics Report.	
5.12.1.9	Assess the busiest times and days by number of calls;	Call Center Metrics		Full	This requirement is addressed in the Avaya Call Metrics Report.	
5.12.1.10	Record calls to assess whether answered accurately;	Call Center Metrics		Full	This requirement is addressed in the Quality Monitoring Policy.	
5.12.1.11	Measure and report average speed to answer;	Call Center Metrics		Full	This requirement is addressed in the LA CSoC Call Reporting documentation.	
5.12.1.12	Establish separate call tracking and record keeping for tracking and monitoring provider and member phone lines;	Call Center Metrics		Full	This requirement is addressed in the LA CSoC TMR Report.	
5.12.1.13	Track and report on nature of calls;	Call Center Metrics		Full	This requirement is addressed in the LA CSoC TMR Detail Report.	
5.12.1.14	Track and monitor call abandonment rates, which shall not exceed five percent (5%) monthly.	Call Center Metrics		Full	This requirement is addressed in the LA CSoC Call Reporting documentation.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.12.1.15	Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;	P/P for backup system		Full	This requirement is addressed in the Member Services Telephone Line and Standards Policy.	
5.12.1.16	Record types of calls and call responses (e.g., where the member was referred); and	P/P for recording calls		Full	This requirement is addressed in the PAHP's Call Documentation.	
5.12.1.17	Inform the member to dial 911 if there is an emergency.	ACD script		Full	This requirement is addressed in the LA CSoC Toll-Free Routing Policy.	
5.13	**Members' Rights and Responsibilities**					
5.13.1 5.13.1.1	MEMBER RIGHTS The rights afforded to current members are detailed in the Member's Bill of Rights shall be provided to Members or their families/caregivers as part of the new member information in the member handbook, and upon request by a member or his/her family/caregiver/ guardian. The information shall be written at a reading comprehension level no higher than a fifth grade level, or as determined appropriate by LDH. The minimum written information shall address 42 CFR §438.100 and include:	P/P for Members' Bill of Rights Members' Bill of Rights Evidence that Members' Bill of Rights has been tested against the reading level standard		Full	This requirement is addressed in the Medicaid: Enrollee Rights and Responsibilities Policy, the Members' Rights and Responsibilities Policy, and in the member handbook.	
5.13.1.1. 1	The right to diagnosis, arrangement of plan of care, and appropriate treatment and services to the fullest extent possible; these services should be provided timely and with written documentation.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1. 2	The right to receive information as described in 42 CFR §438.10 and as outlined in this contract.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.	The right to be treated with respect and with	P/P for HIPAA Compliance		Full	This requirement is addressed in the	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
3	due consideration for his or her dignity and privacy;	Members' Bill of Rights			member handbook.	
5.13.1.1.4	The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.5	The right to receive rehabilitative services in a community or home setting.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.6 5.13.1.1.6.1 5.13.1.1.6.2 5.13.1.1.6.3	The right to participate in decisions regarding his/her care, or decisions for care of someone for whom they serve as legal guardian, including the right to refuse treatment; and the right to the following: 1. Complete information about his/her specific condition and treatment options, regardless of cost or benefit coverage, and the right to seek second opinions. 2. Information about available experimental treatments and clinical trials and how such research can be accessed, and 3. Assistance with care coordination	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.7	The right to be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation, or convenience. Restraint and seclusion may only be utilized by facilities in emergency situations to prevent an imminent threat of extreme violence or self-destructive behavior.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.8	The right to appeal or express a concern about the Contractor, or the care it authorizes, and receive a response in a reasonable period of time.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
5.13.1.1.9	The right of the member or his/her legal guardian to receive a copy of his/her medical records, including the right to request that the records be amended or corrected as allowed in 45 CFR 164.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.10	The right to determine to whom and what portions of his or her treatment records are released to a third party.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.11	The right to access one's attorney or legal representatives, including access to facilities for private communication.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.12	The right to implement an advance directive as required in 42 CFR 438.10(g)(2); update written information as required in 42 CFR 438.6(i)(3) and (4), which specifies that the written information shall reflect changes in state law as soon as possible, but no later than ninety (90) days after the effective date of change; and the right to file a grievance concerning noncompliance with the advance directive requirements to LDH or other appropriate certification or licensing agencies, as allowed in 42 CFR Part 438 Subpart I.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.13	The right to choose his or her provider to the extent possible and appropriate, in accordance with 42 CFR 438.6(m).	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.14	The right to be furnished behavioral health care services in accordance with 42 CFR 438.206 through 438.210.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.15	Freedom to exercise the rights described herein without any adverse effect on the member's treatment by LDH, the Contractor or the Contractor's subcontracts or network providers.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.16	The right to be treated with dignity and respect by	Members' Bill of Rights		Full	This requirement is addressed in the	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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 professional, competent, and ethical work force in the least restrictive manner as possible.				member handbook.	
5.13.1.1.17	The right to a safe treatment environment that affords protection from harm and appropriate personal privacy.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.18	The right to be given the opportunity to practice one's spirituality on a voluntary basis, limited only when inconsistent with safety and order of operations for the facility.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.19	The right to engage in appropriate leisure, recreational, and other activities.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.20	The right to refuse treatment or services unless ordered by a court to participate, or unless such refusal would pose a danger to self or others.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.21	The right to receive reasonable accommodations in accordance with the Americans with Disabilities Act including but not limited to provision of supports and services.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.22	The right to exercise the entitlements described in this Member Bill of Rights without punishment, including punishment in the form of denial of any appropriate, available treatment.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.23	In accordance with La.R.S. 28:171, the right to not be presumed incompetent or held incompetent except as determined by a court of competent jurisdiction. The determination of incompetence shall be separate from the judicial determination of whether the person is a proper subject for involuntary commitment.	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	
5.13.1.1.24	The right to be informed of the aforementioned rights both orally and in writing upon admission	Members' Bill of Rights		Full	This requirement is addressed in the member handbook.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and upon request.					
5.13.1.2	The Member Bill of Rights shall be in addition to, and not in place of, any other statutory rights.					
5.13.1.3	The Member Bill of Rights shall not be interpreted so as to contradict or conflict in any way with any applicable provision of federal or state laws, rules, or regulations.					
5.13.2	Member Responsibilities					
5.13.2.3 5.13.2.3.1 5.13.2.3.2 5.13.2.3.3 5.13.2.3.4 5.13.2.3.5 5.13.2.3.6 5.13.2.3.7 5.13.2.3.8	The Member's responsibilities shall include, but are not limited to: 1. Being familiar with Contractor procedures to the best of the member's abilities; 2. Calling or contacting the Contractor to obtain information and have questions answered; 3. Providing participating network providers with accurate and complete medical information; 4. 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; 5. Living healthy lifestyles and avoiding behaviors known to be detrimental to their health; 6. Following the grievance and appeals process established by the Contractor if they have a disagreement with a provider or the Contractor; 7. Following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment	Member Handbook		Full	This requirement is addressed in the member handbook, Member Rights and Responsibilities section.	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	cannot be followed, as soon as possible; and 8. Keeping any agreed upon appointments, follow-up appointments, accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.					
5.14	**Notice to Members of Provider Termination and Changes**					
5.14.1	Provider Contract Termination and Changes					
5.14.1.1	If a member has been receiving a prior authorized course of treatment, the Contractor shall provide notice to the member or the parent/legal guardian as appropriate or the custodial state agency if applicable when the treating provider becomes unavailable or is terminated. The written notice shall be provided to the member and LDH within seven (7) calendar days from the termination of the provider contract or from the date the Contractor becomes aware of the unavailability of the provider, if it is prior to the change occurring.	P/P for notification of provider termination or change Example of this communication if applicable		Full	This requirement is addressed in the Provider is Leaving the Network Procedure, page 2. The PAHP provided the Provider Termination template as evidence of compliance with this requirement.	
5.14.1.2	The Contractor shall provide notice to the member, if a member has been receiving a prior authorized course of treatment, within fifteen (15) calendar days of the Contractor becoming aware of a provider becoming unable to care for members for reasons including but not limited to an illness, death, relocation from the service area, when a provider fails credentialing or when a provider is displaced as a result of a natural or man-made disaster.	P/P for notification of provider termination or change Example of this communication if applicable		Full	This requirement is addressed in the Provider is Leaving the Network Procedure, page 2. The PAHP provided the Provider Termination template as evidence of compliance with this requirement.	
5.14.1.3	When the termination was initiated by the provider, once the Contractor becomes aware, within fifteen (15) calendar days, the Contractor shall make a good faith effort to give written	P/P for notification of provider termination or change Example of this		Full	This requirement is addressed in the Provider is Leaving the Network Procedure, page 2. The PAHP provided the Provider Termination template as evidence of	

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	notice of a provider's termination to each member who received care from or was seen on a regular basis by the provider.	communication if applicable			compliance with this requirement.	
5.15	**Oral and Written Interpretation Services**					
5.15.1	In accordance with 42 CFR §438.10(c) and (d), the Contractor must make real-time oral and signing interpretation services (bilingual staff and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats) available free of charge to each member and their family. This applies to all non-English languages, not just those that Louisiana specifically requires in written translation (Spanish and Vietnamese). The Contractor must notify its members that oral and signing interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.	P/P for availability of interpretation services		Full	This requirement is addressed in the Non-discrimination and Language Access Policy.	
5.15.2	Member education materials shall be available in English, Spanish, and Vietnamese. In addition, the Contractor shall ensure that translation services are provided for written member education materials and provided in any language that is spoken as a primary language by at least five percent (5%) of Contractor members. LDH-BHSF will provide the Contractor with a list of prevalent non-English languages spoken by members by parish via the Preferred Language Statewide by Parishlink. Written materials must also be available in alternative formats and in an	P/P for availability of translated materials		Substantial	This requirement is addressed in the Non-discrimination and Language Access Policy, which provides a high-level explanation of the PAHP's translation and interpreter services. This policy does not explicitly address the 5% requirement, or the 90-day requirement. **Recommendations:** The PAHP should update the Non-discrimination and Language Access Policy to	**Magellan's Nondiscrimination and Language Access policy has been updated to include this information.**

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	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
	appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. 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 afford a reasonable chance for all members to understand how to access the Contractor and use services appropriately.				include the language required in the standard.	

Provider Network Requirements

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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. PROVIDER NETWORK REQUIREMENTS						
6.1 General Provider Network Requirements						
6.1.1	The Contractor must maintain a network of qualified Medicaid behavioral health and waiver service providers that is supported by written network provider agreements and that is sufficient in numbers and locations to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical disabilities.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Development Plan 6.1.	
6.1.2	The Contractor is expected to maintain and enhance its existing network that provides a comprehensive array of behavioral health services with a geographically convenient flow of members among culturally-competent, qualified network providers as necessary to meet their identified needs. The provider network shall be designed to reflect the needs and service requirements of the CSoC member population.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Development Plan 6.1.	
6.1.2.1	The Contractor shall be required to contract with at least one Federally Qualified Health Centers (FQHC) in each LDH region if there is an FQHC which can provide substance use disorder services or specialty mental health services under state law and to the extent that the FQHC meets the required provider qualifications. Contractor will notify LDH if there are any barriers or issues with contracting with FQHCs.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 2 and page 4.	
6.1.2.2	The Contractor shall also be required to maintain within their network a sufficient number of Wraparound agencies and providers of specialized CSoC services including Family Support Organization(s) which provide Youth Support and	Network Provider Development and Management Plan P/P for Provider Network		Substantial	This requirement is partially addressed in Louisiana Coordinated System of Care: Network Development and Management Plan.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	Training (YST), Parent Support and Training (PST), as well as providers of Independent Living/Skills Building (ILSB) and Short Term Respite (STR).				The evidence addresses the requirement to include wraparound agencies, family support organizations, and providers of independent living/skills building (ILSB) and short-term respite (STR). The evidence addresses the requirement of family support organizations to provide youth support and training (YST) and parent support and training (PST). Although the requirement to maintain a sufficient number of some provider services, specifically providers of ILSB and STR in rural areas of the state, Magellan is working to enhance the number of practitioners in these areas. Its latest Geo Access Reports, outside of the review period, show an increase.	
6.1.3	The Contractor is expected to begin this contract with a provider network that, at a minimum, will include all eligible behavioral health service providers meeting federal and state rules, laws and regulations, who were contracted to participate in the provider network on November 1, 2018.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Specialized Behavioral Health Network Providers Report. This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 3 and page 4.	
6.1.4	The Contractor shall maintain and expand their provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The Contractor will collaborate with LDH when barriers to expansion are encountered.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 34, page 35, page 37, and page 38.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.1.5	The Contractor will work with the providers offering services as necessary to address the needs of those eligible for the CSoC. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 2 and page 4.	
6.1.6	The Contractor shall ensure its provider network offers an appropriate range of specialty behavioral health services that is adequate for the anticipated number of members for the service area, including compliance with the waivers and Medicaid State Plan requirements.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.1.7 6.1.7.1 6.1.7.2 6.1.7.3 6.1.7.4 6.1.7.5	The Contractor is required to contract with providers of behavioral health services who: .1 Are appropriately licensed and/or certified, .2 Meet the certification and applicable licensing criteria, .3 Meet accreditation and other federal and state requirements, inclusive of requirements and qualifications established in the Medicaid Behavioral Health Services Provider Manual, as applicable, .4 Agree to the standard contract provisions, and .5 Elect to participate.	Network Provider Development and Management Plan P/P for Provider Network <u>File Review</u>		Full	This requirement is partially addressed in the Network Practitioner Credentialing and Re-credentialing Policy, page 3. This requirement is partially addressed in the Provider Credentialing Activities Process Policy, page 1 and page 2. **<u>File Review Results</u>** Credentialing file review results: Five (5) of 5 credentialing files reviewed were compliant. Re-credentialing file review results: Five (5) of 5 re-credentialing files reviewed were compliant.	
6.1.8	The Contractor shall ensure that within the provider network, recipients have a choice of providers, which offer the appropriate Level of Care (LOC) and may change providers in accordance with 42 CFR §438.3(l) and the Medicaid home and community-based waiver	P/P for Provider Network		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 3 and page 4. This requirement is addressed on the	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	requirements pertaining to Freedom of Choice (FOC).				Specialized Behavioral Level of Care Report. This requirement is addressed in the Coordinated System of Care Member Handbook, page 11.	
6.1.9	The Contractor shall maintain a directory of qualified providers divided into specific types of services and types of members the provider serves. The list will continue to be made available to the public in near real time through the Contractor website and to members, the member's family/caregiver, and referring providers in electronic format. The Contractor provider types shall match the provider types approved in Louisiana and be delineated by zip code.	P/P for Provider Network Provider Directory		Full	This requirement is addressed on the Magellan Healthcare website: https://www.magellanoflouisiana.com/for-members/find-a-provider/.	
6.1.10	The Contractor shall assure that the network has a sufficient number of prescribers and other qualified service providers to deliver services during evenings and weekends. The Contractor shall ensure that services included in this contract are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.	P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 3.	
6.1.11	The Contractor shall provide technical assistance and network development training (e.g., billing, CSoC services and authorization, linguistic/cultural competency, etc.) for its providers and maintain records of such training, which shall be made available to LDH upon request.	Example training materials and sign-in sheets		Full	This requirement is partially addressed in the Magellan Healthcare Inc. Provider Handbook Supplement for the Louisiana Coordinated System of Care, page 7 and page 18. The evidence addresses the requirement for network development training and the provision of technical assistance. This requirement is addressed on the Magellan Healthcare website:	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					https://www.magellanoflouisiana.com/for-providers/training-events/provider-training-requirements/. The evidence addresses the requirement for network development training. This requirement is addressed in the Specialized Behavioral Health Cultural Competency Report.	
6.1.12 6.1.12.1 6.1.12.2 6.1.12.3 6.1.12.4	The Contractor shall respond to provider inquiries by coordinating with, or expeditiously referring inquiries to, persons within the Contractor's organization that can provide a timely response and shall be responsible for: .1 Expeditiously developing network provider agreements and enforcing the agreement terms. .2 Managing the seamless transition of services or providers for members because of a change in network composition. .3 Performing credentialing of qualified service providers consistent with 42 CFR Part 438 and applicable state regulations, including credentialing of prescribers, practitioners, facilities, providers and WAAs. .4 Ensuring that provider complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH). If not resolved within thirty (30) business days, the CSoC Contractor must document why the issue goes unresolved; however, the issue must be resolved within ninety (90) calendar days.	P/P for Provider Network P/P for Provider Credentialing/ Re-Credentialing P/P for Provider Complaints		Full	6.1.12.4 – This requirement is partially addressed in the Magellan Healthcare Inc. Provider Handbook Supplement for the Louisiana Coordinated System of Care, page 34. The provider handbook, page 34, addresses complaints that are not resolved within 30 business days.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.1.13	The Contractor shall evaluate every prospective provider's ability to perform the activities to be delegated prior to contracting with any provider. The Contractor must ensure the provider has not been found to have committed fraud as per the requirements of Section 13 of this contract.	P/P for credentialing P/P for Fraud, Waste, and Abuse		Full	This requirement is partially addressed in the Network Practitioner Credentialing and Re-credentialing Policy. The Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors) Policy addresses the requirement of checking for fraud.	
6.1.14	All network providers shall be in compliance with Americans with Disabilities Act (ADA) requirements and provide physical access for members with disabilities.	Network Provider contracts P/P for disability services		Full	This requirement is addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 13.	
6.1.15 6.1.15.1 6.1.15.2 6.1.15.3 6.1.15.4 6.1.15.5	The Contractor is not obligated to continue to contract with a provider that: .1 Does not meet the contractual standards (e.g., fails to meet all health and safety standards and maintain all required Health Standards licenses), .2 Does not meet provider qualifications and requirements as established by federal and state rules, laws and regulations, .3 Does not provide high quality services, or .4 Demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the Contractor and LDH.	Network Provider Contracts P/P for credentialing P/P for utilization management		Substantial	This requirement is addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 3 and page 8. The evidence is partially addressed in the Provider Utilization and Quality Profile Report, where provider utilization of services is tracked. **Recommendation:** The PAHP should include the language in the standard in a policy indicating that it does not have an obligation to continue to contract with a provider that demonstrates outlier utilization of services compared to peer providers with similarly acute populations based on the expectations of the contractor and LDH.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.1.16	The Contractor shall not discriminate:					

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.1.16.1	The Contractor's provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P/P for provider selection P/P for anti-discrimination		Full	This requirement is addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 12.	
6.1.16.2	The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification in compliance with 42 CFR §438.12.	P/P for provider selection P/P for anti-discrimination		Full	This requirement is partially addressed in the Magellan Healthcare Inc. Provider Agreement, page 12. Though complaint with this standard, the PAHP may want to consider referencing 42 CFR §438.12 in their provider agreement	
6.1.16.3 6.1.16.3.1 6.1.16.2 6.1.16.3	The prohibition of provider discrimination found in 42 CFR §438.12(a) may not be construed to: 1. Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. 2. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. 3. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to members.	P/P for provider selection P/P for anti-discrimination		Full	This requirement is addressed in the Louisiana Coordinated System of Care Program Addendum to Magellan Healthcare, Inc. Provider Agreement, page 12.	
6.1.17	If the Contractor declines to include individuals or groups of providers in its provider network, it must notify LDH and give the affected providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.	Example of this communication if applicable		Minimal	Although Magellan has not declined anyone from joining in its network, it should incorporate this standard into an existing policy or develop a new one. On-site, Magellan indicated that they would incorporate the standard in a policy.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.1.18	The Contractor shall at least semi-annually	P/P for demographic data		Full	This requirement is partially addressed in the	

Provider Network Requirements						
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	validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted network providers.	validation			Magellan Healthcare, Inc. 2019 Handbook for the National Provider Network, page 14. The evidence states that providers are required to report administrative practice changes. The evidence does not address the requirement for the semiannual validation of provider demographics. This requirement is addressed in the Magellan Provider Demographic Validation Attestation (8.4.1.7). The evidence addresses the requirement for semiannual validation of provider demographics.	
6.1.19	The Contractor shall have a fully operational network of behavioral health crisis response providers offering an array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour hotline, crisis counseling, crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, and crisis stabilization for children. The Contractor may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warm line, mobile crisis teams, collaboration with law enforcement, and crisis stabilization in an alternative setting.	P/P for Provider Network		Full	This requirement is partially addressed in the Louisiana Coordinated Care Program Addendum to Magellan Healthcare Inc. Provider Agreement, page 3 and page 6. The evidence addresses the requirement of providers offering crisis services 24 hours per day, 7 days per week. This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 34. The evidence addresses the requirement of a 24-hour hotline and crisis counseling. The Behavioral Health provider manual describes the PAHP's Crisis Stabilization Unit.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.1.20	The Contractor shall develop, maintain and provide LDH and members access to electronic provider directory that contains near real time information identifying, according to zip code and by provider type, provider availability, and any member parameters for service population (e.g., child, Spanish-speaking, etc.).	P/P for provider directory		Full	This requirement is partially addressed in the Network Provider Data Maintenance and Data Integrity Policy, page 2. This requirement is fully addressed on the Magellan Healthcare website, https://www.magellanoflouisiana.com/for-members/find-a-provider/. This requirement addresses the requirement of "near real time" information. Magellan states on the website that the online provider directory is updated daily.	
6.1.21	The Contractor shall not subcontract network management, network reporting, or assurance of network sufficiency.	P/P for network management, network reporting, and assurance of network sufficiency		Minimal	Magellan indicated that it does not subcontract network management, but there was no evidence presented that indicated that they do not subcontract. The standard should be incorporated into a policy. On-site, Magellan indicated that they would incorporate the standard in a policy.	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.
6.1.22	If shortages in provider network sufficiency are identified, the Contractor shall perform outreach and recruiting efforts to enhance and further develop needed access to providers. The Contractor will execute single case agreements when a clinical need is identified for a member and no network provider is available to meet that particular need.	P/P for provider network shortage		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 8.	
6.1.23	The Contractor shall comply with network and payment requirements for members who are identified as Indians in accordance with 42 CFR §438.14.	Provider Network Development and Management Plan		Minimal	Although Magellan adheres to this standard, and pays according to the requirement, there was no evidence presented indicating that the standard is followed. Magellan should incorporate the language in the	Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					standard in a policy. On-site, Magellan indicated that they would incorporate the standard in a policy.	
6.2	**Network Development and Management Plan**					
6.2.1	The Contractor shall develop and maintain a provider Network Development and Management Plan. Contractor will address barriers to CSoC waiver and non-waiver service development with the goal of ensuring that the provision of specialized behavioral health and waiver services to CSoC children/youth will occur consistent with the goals and principles of LDH [42 CFR §438.207(b)].	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.2	The Network Development and Management Plan shall be submitted to LDH when significant changes to the network occur as defined in 42 CFR §438.207(c)(3). The Plan shall include the Contractor's process to develop, maintain, manage and monitor the provider network that is supported by written agreements and is sufficient to provide adequate access to all required services included in the contract. A Network Development and Management Plan shall be submitted to LDH annually.	Example of LDH communication if applicable		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan. On-site, LDH confirmed that Magellan submitted the Plan.	
6.2.3	The plan shall contain separate sections for each provider type for covered services described in this contract for children.	Provider Network Development and Management Plan		Full	On-site, LDH confirmed that the format of the Plan was acceptable.	
6.2.3.1 6.2.3.1.1 6.2.3.1.2 6.2.3.1.3 6.2.3.1.4	In establishing and maintaining the network, the Contractor shall consider and report on the following: 1 CSoC enrollment. 2 Utilization of services, taking into	Provider Network Development and Management Plan Reports on these measures GeoAccess Report		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, pages 5-9, 21-36, and 39.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.2.3.1.5 6.2.3.1.6 6.2.3.1.7 6.2.3.1.8 6.2.3.1.9	consideration the characteristics and behavioral healthcare needs of CSoC children and youth. 3 The numbers of network providers who are not accepting new Medicaid patients. 4 The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, waiver requirements, and whether the location provides physical access for Medicaid enrollees with disabilities. 5 Development of network capacity in collaboration with state agencies, with the understanding that the network capacity requirements may change due to the needs of individual children. 6 Development and implementation of policies and procedures to monitor and demonstrate that the network is of size, scope, and types of providers to deliver all covered behavioral health services and satisfy all the service delivery requirements of this contract and the Medicaid Behavioral Health Services Provider Manual. 7 If the Contractor is not able to deliver a medically necessary covered behavioral health service, the Contractor must adequately and timely cover these services utilizing an out-of-network provider to deliver the same service via a provider with at least the same type of training, experience, qualifications and specialization as within the provider network.. The Contractor shall authorize services in accordance with Section 8 and reimburse the out-of-network provider in these circumstances in accordance with Section 9.. 8 Out-of-network providers shall meet at least a minimum standard of qualification. Out of state providers shall have proof of the equivalent of	P/P for utilizing out-of-network providers			This requirement is addressed in the Quarterly Report WY2 Q3. The Provider Network Plan indicates that members can search for providers who provide wheelchair accessibility. As per LDH, Magellan utilizes a format approved by LDH to submit the Quarterly Network Status reports that mirrors the annual Network Development and Management Plan.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	Louisiana licensing requirements. In state providers shall be licensed with HSS or the respective state board or agency. All out-of-network providers shall have applicable accreditations. Upon request, the Contractor shall submit proof to LDH of the out-of-network provider meeting these requirements. 9 If a member needs a specialized service that is not available through the network, the Contractor will arrange for the service to be provided outside the network if a qualified provider is available. Transportation will be provided and reimbursed through Medicaid when eligible.					
6.2.4 6.2.4.1	The Network Development and Management Plan shall also include the following requirements: .1 The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted behavioral health services and CSoC services, including providers specializing in services (e.g., Developmentally Disabled (DD) population, sexual offending behaviors, and early childhood development) that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated enrollees.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Magellan Healthcare Inc. Louisiana Coordinated System of Care: Network Development and Management Plan, page 3.	
6.2.4.2 6.2.4.2.1 6.2.4.2.2	An annual needs assessment to identify unmet service needs in the service delivery system. The needs assessment shall analyze and include: 1 Volume of single case agreements and out-of-network and referrals; 2 Specialized service needs of members	Needs Assessment report		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 8 and page 26.	
6.2.4.2.3 6.2.4.2.3.1 6.2.4.2.3.2	Growth trends in eligibility and enrollment, including 1 Barriers to sufficiently addressing unmet	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
6.2.4.2.3.3	needs 2 What has been done to address unmet needs, 3 Current and desired service utilization trends, including prevalent diagnoses; age, gender, and race/ethnicity and cultural characteristics of the enrolled population by CSoC region; best practice approaches; and network and contracting models consistent with LDH, CSoC, and Wraparound Goals and Principles.				Plan.	
6.2.4.3 6.2.4.3.1 6.2.4.3.2 6.2.4.3.3 6.2.4.3.4	What has been done to address unmet needs, accessibility of services, including: 1 The number of current network providers by individual service in the network who are not accepting new referrals or new Medicaid members and plan for updating on a regular, reoccurring basis as close to real times as possible. 2 The geographic location of providers and members considering distance, travel time, and available means of transportation. 3 Availability of services and appointments with physical access for persons with disabilities. 4 Any service access standards detailed in a SPA or waiver.	Provider Network Development and Management Plan Provider List GeoAccess Report P/P for disability access		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan. This requirement is partially addressed in the Quarterly Report WY2 Q3.	
6.2.4.4	GEO mapping and coding of all network providers for each provider type to LDH quarterly, upon material change or upon request.			Full	This requirement is partially addressed in the Quarterly Report WY2 Q3.	
6.2.4.5	The Network Development and Management Plan shall state that the CSoC 's provider network meets requirements with regard to cultural competence and linguistics as follows:					
6.2.4.5.1	Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206 and §440.262.	Provider Network Development and Management Plan		Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 12.	IPRO's recommendation will be included in the Annual Network Development Plan for the

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 Network Development Plan captures the number of providers that provide sign language services, but there is no evidence that members' sign language needs are assessed and whether the number of providers who provide sign language services is sufficient. **Recommendation:** The PAHP should evaluate the volume of members who require providers who can provide sign language services and evaluate whether the number is sufficient, perhaps through member services outreach to these members or via a survey.	next contract year.
6.2.4.5.2	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:	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan	
6.2.4.5.2.1	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);.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, pages 10-12.	
6.2.4.5.2.2	Assessing the cultural competence of the providers on an ongoing basis, at least annually.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, pages 18 and 19.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					This requirement is partially addressed in the Specialized Behavioral health Cultural Competency Report.	
6.2.4.5.2.3	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.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Magellan Healthcare Inc. Louisiana Coordinated System of Care: Network Development and Management Plan, page 18. The evidence addresses the requirement for the assessment of member satisfaction related to provider cultural competence. The evidence addresses the requirement to capture demographics related to race and ethnicity. The evidence does not address the requirement for annual assessments. Although the annual survey has not yet been administered, it will capture demographics related to age, gender, and parish.	
6.2.4.5.2.4	Assessing provider satisfaction of the services by the CSoC Contractor at least annually.	Provider Network Development and Management Plan		Full	The member survey will be conducted annually, but its conduct will occur outside of the review period.	
6.2.4.5.2.5	Requiring and providing training on cultural competence, including tribal awareness, by obtaining proof of attendance at trainings to CSoC Contractor staff and network providers for a minimum of three (3) hours per year and as directed by the needs assessments.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Magellan Healthcare Inc. Louisiana Coordinated System of Care: Network Development and Management Plan, page 18 and page 19. This requirement is partially addressed in the	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					Magellan Healthcare Inc. Semiannual Reports Cultural Competency February 2019 report.	
6.2.4.5.3	For the purpose of effective communication, the Contractor will ensure people with vision, hearing, or speech disabilities can communicate with, receive information from, and convey information to, the Contractor and those with whom the Contractor subcontracts or enters into a network provider agreement. The covered entity must provide appropriate services when needed to communicate effectively with people who have communication disabilities with regard to the nature, length, complexity, and context of the communication and the person's normal method(s) of communication. Effective communication applies to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, caregiver, custodian, spouse, or companion, in appropriate circumstances.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan, page 18-20.	
6.2.4.6	The Contractor shall include in the plan strategies for continued transformation of service delivery into a comprehensive system that:	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
6.2.4.6.1	Includes network providers designed and contracted to deliver care that is strength-based, family-driven, community-based, and culturally competent.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.2	Is of sufficient size and scope to offer members a choice of providers for all covered behavioral health services.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.3	Develops and expands the use of evidence-based	Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	models to deliver covered services	Development and Management Plan			Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.4	Includes specific services for children eligible for the CSoC as defined in this contract.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.5	Targets the development of family and community-based services for children/youth in out-of-home placements based on services as defined in the Medicaid Behavioral Health Services Provider Manual.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.6	Contractor will work with WAA providers to increase access to family and community-based services, optimizing the use of natural and informal supports and reducing reliance on out-of-home placements.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.7	Improves and increases services available for individuals with behavioral health and developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and includes long-range fiscal planning to promote training and fiscal sustainability.	Provider Network Development and Management Plan		Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 37. The evidence addresses the requirement of increasing services for individuals with behavioral health and developmental disabilities. The evidence does not address the specific inclusion of autism spectrum disorders. The evidence does not address long-range fiscal planning to promote training and fiscal sustainability.	This standard will be assessed and reported in Magellan's Network Development Plan for the upcoming contract year.

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Recommendation: The PAHP should include autism and fiscal planning to promote training and sustainability in the Network Develop and Management Plan. On-site, Magellan indicated that the standard will be fully reflected in the next iteration of the plan.	
6.2.4.6.8	Assesses annually the number of providers serving members with behavioral health and developmental disabilities and if the needs are being met for this population in the state. This assessment shall include:	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan.	
6.2.4.6.8.1	How many members are being served out-of-state due to lack of appropriate services in-state?	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 8.	
6.2.4.6.8.2	Do these providers have waiting lists?	Provider Network Development and Management Plan		Substantial	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 5. On-site, Magellan reported that they do not have providers with waiting lists, but the follow-up documentation does not appear to have this element documented. **Recommendation:** The PAHP should add this element to their provider monitoring tool.	The provider monitoring tool and tracking system will be updated to include this element. The documents will be sent to the LDH for approval by 8/31/19.
6.2.4.6.8.3	Are access to care standards being met by these providers?	Provider Network Development and Management Plan		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 5.	

Provider Network Requirements						
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6.2.4.7	Maintain minimum standards for certified peer and family support as set by LDH.	Provider Network Development and Management Plan		Full	This requirement is addressed in the Family Support Organization: Implementation Assessment Report.	
6.2.4.8	Documentation of accessibility to a sufficient number of qualified oral interpreters, bilingual staff, and licensed sign language interpreters to deliver oral interpretation, translation, sign language, disability-related services, provide auxiliary aids and alternative formats, including formats accessible to the visually impaired.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, page 18 and page 20. The evidence addresses access to oral interpreters.	
6.2.4.9	A process for expedited and temporary credentials for out of network providers. Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, administrative and onsite audits and provider profiling.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan, pages 33, 34, and 35. The evidence addresses the requirement of recruiting, selecting, credentialing, re-credentialing, and contracting with providers in a manner that incorporates quality management, utilization, administrative and on-site audits, and provider profiling. The evidence addresses the requirement of a process for expedited and temporary credentials for out-of-network providers on page 20 of the Plan.	
6.2.4.10	An evaluation of the initial Network Development and Management Plan, including evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions.	Provider Network Development and Management Plan		Full	This requirement is partially addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan. The evidence addresses the requirement of evaluation of the success of proposed interventions and barriers to	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					implementation.	
6.2.5 6.2.5.1 6.2.5.2 6.2.5.3 6.2.5.4 6.2.5.5 6.2.5.6 6.2.5.7 6.2.5.8	Upon request and as part of its Network Development and Management Plan, the Contractor shall submit provider profiling data to LDH that includes: 1 Eligibility/enrollment data; 2 Utilization data; 3 The number of single case agreements by service type; 4 Treatment and functional outcome data; 5 Members diagnosed with developmental/cognitive disabilities; 6 Number of prescribers required to meet behavioral health members' medication needs; 7 Provider complaint data; and 8 Issues, concerns, and requests identified by other state agency personnel, local agencies, and community stakeholders.	Example of LDH communication if applicable		Full	This requirement is partially addressed by the Provider Profile Report and the Provider Performance Report (template). All eight standards are addressed in the 2019 Network Development Plan. As a result, the review determination has been changed from "Substantial" to "Full".	Magellan's 2019 Network Development Plan addresses standards 3, 5, 6 & 8. The final version of this document was not submitted to the IPRO team in advance of the audit, but it was provided during the onsite review.
6.2.6	Contractor Network Development and Management policies shall be subject to approval by LDH.			Full	On-site, LDH confirmed approval.	
6.3	**Network Standards and Guidelines**					
6.3.1 6.3.1.1	Access Standards 1 The Contractor shall ensure access to healthcare services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care, facility wait list) in accordance with the provision of services under this contract and in accordance with 42 CFR §438.206(c). The Contractor shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional personnel for the provision of services, including all specialized behavioral health emergency	P/P for access to services		Full	This requirement is addressed in the Louisiana Coordinated System of Care: Network Development and Management Plan. This requirement is partially addressed in the Quarterly Report WY2 Q3.	

Provider Network Requirements						
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	services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:					
6.3.1.1.1 6.3.1.1.1.1	Travel Time and Distance Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs)) and to psychiatrists for members living in rural parishes shall not exceed thirty (30) miles or sixty (60) minutes, whichever is less, for one hundred percent (100%) of members.			Minimal	The evidence submitted by Magellan does not address the requirement for travel to not exceed thirty (30) miles or sixty (60) minutes for one hundred percent (100%) of members. The evidence indicates that Magellan did not assess time and distance according to the contract standards. Magellan used the standard of 60 miles (rather than the contractual 30 miles). Psychologists – standard not met. Advanced practiced registered nurses – standard not met. LCSWs – standard not met. Psychiatrists – standard not met. On-site, Magellan indicated that it is working to improve access to specialists where the standard is not met. **Recommendation:** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract (30 miles or 60 minutes for 100% of the members).	The Geo Access Report template has been updated to reflect the current standards.
6.3.1.1.1.2	Travel distance to behavioral health specialists (i.e. psychologists, medical psychologists,			Minimal	The evidence submitted by Magellan does not address the requirement for travel to not	The Geo Access Report template has been updated

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists for members living in urban parishes shall not exceed fifteen (15) miles or thirty (30) minutes, whichever is less, for one hundred percent (100%) of members.				exceed fifteen (15) miles or thirty (30) minutes for one hundred percent (100%) of members. The evidence indicates that Magellan did not assess time and distance according to the contract standards. Magellan used the standard of 30 miles (rather than the contractual 15 miles). Psychologists – standard not met. Advanced practiced registered nurses – standard not met. LCSWs – standard not met. Psychiatrists – standard was met. **Recommendation:** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract (30 miles or 60 minutes for 100% of the members).	to reflect the current standards.
6.3.1.1.1.3	Travel distance to specialized behavioral health outpatient non-MD services (excluding behavioral health specialists) shall not exceed sixty (60) miles or ninety (90) minutes, whichever is less, for urban members and ninety (90) miles or one hundred and twenty (120) minutes, whichever is less, for rural members. Maximum time for appointment shall not exceed appointment availability requirements for specialized behavioral health emergent, urgent and routine care.			Minimal	This requirement is not accurately reflected in the Geo Access Reports. **Recommendation:** The PAHP should revise the footnote in the Geo Access Report to state the access standard according to the contract requirements.	The Geo Access Report template has been updated to reflect the current standards.
6.3.1.1.2	The Contractor shall report on service accessibility			Full	This requirement is addressed in Network	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 a manner which allows for comparisons to the industry standards. Calculations for access to behavioral healthcare shall include travel time, distance, population density, and provider availability variables.				Access Analysis Created for Louisiana Coordinated System of Care Created by Magellan Health Inc.	
6.3.1.1.3	Requests for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.			Not applicable	Magellan did not request any exceptions.	
6.3.1.1.4	There shall be no penalty if the member chooses to travel further than established access standards in order to access a member's provider of choice. The member shall be responsible for travel arrangements and costs.					
6.3.1.2 6.3.1.2.1	Scheduling/Appointment Waiting Times .1 The Contractor shall have policies and procedures for appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The Contractor shall disseminate these appointment standard policies and procedures to its network providers and to its members and include this on website, in member and provider handbooks, in provider contracts and shall be made available to LDH for review upon request. The Contractor shall monitor compliance with appointment standards and shall have a CAP when appointment standards are not met.			Substantial	This requirement is partially addressed in the Provider Handbook Supplement for the Louisiana Coordinated System of Care, pages 18 and 48. This requirement is partially addressed on the Magellan Healthcare website: https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-resources/member-access-to-care/. This requirement is partially addressed in the Network Appointment Availability Report, page 2. The requirement is partially addressed by the Accessibility of Service and Care Policy. The provider handbooks include discussion of appointment standards.	

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 evidence did not address the requirement to include the appointment standards in the member handbook.	
6.3.1.2.2	The Contractor shall require all participants in the provider network to have an appointment system for contracted services that is in accordance with prevailing behavioral health community standards as specified below:					
6.3.1.2.2.1	Provisions must be available for obtaining emergent care twenty-four (24) hours per day, seven (7) days per week. Emergent, crisis or emergency services must be available at all times. An appointment shall be available within one (1) hour of request.			Full	This requirement is addressed in the Provider Handbook Supplement for the Louisiana Coordinated System of Care, page 18. The one hour appointment standard for emergency services is stated on p. 18 of the Provider Handbook. As a result, the review determination has been changed from "Substantial" to "Full".	The 1-hour standard is reflected on page 18 of Magellan's LA CSoC Provider Handbook.
6.3.1.2.2.2	Provisions must be available for obtaining urgent care twenty-four (24) hours per day, seven (7) days per week. An appointment shall be available within forty-eight (48) hours of request.			Full	This requirement is addressed in the Provider Handbook Supplement for the Louisiana Coordinated System of Care, page 18.	
6.3.1.2.2.3	Routine, non-urgent behavioral healthcare shall be available with an appointment within fourteen (14) days of referral.			Full	This requirement is addressed in the Provider Handbook Supplement for the Louisiana Coordinated System of Care, page 18.	
6.3.1.2.2.4	None of the above access standards shall supersede the requirements in the waivers or Medicaid State Plan.					
6.3.2	The Contractor shall submit an attestation ensuring adequate capacity as defined by the					

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	contractual GEO Access Standards and services at the time it enters into a contract with LDH and at any time there has been a change in the Contractor's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population).					

Care Management

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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	**Care and Utilization Management**					
7.1	**Care Management General Requirements**					
7.11	Care management is the overall system of medical and psychosocial management encompassing, but not limited to, UM, care coordination, discharge planning following restrictive levels of care, continuity of care, and care transition. Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring behavioral health services and linkages to primary medical care services as needed. These activities shall include scheduling assistance, monitoring, and follow-up for member(s) requiring behavioral health services.	P/P for CM P/P for discharge planning P/P for continuity of care P/P for care transitioning		Full	This requirement is addressed in Louisiana CSoC UM/CM Program description 2018-2019, Follow-up After Hospitalization Procedure, Medicaid Care Coordination Policy, Care Coordination Continuity of Care, and Care Transition Workflow.	
7.1.2	The Contractor shall develop and maintain a care management function that ensures covered behavioral health services are available when and where individuals need them. The Contractor shall provide services that are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and be in compliance with 42 CFR §438.210. The care management system shall have LMHP care managers (CMs) that respond twenty-four (24) hours per day, seven (7) days per week, and three hundred and sixty-five (365) days per year to members, their families/caregivers, legal guardians, or other interested parties calling on behalf of the member. Failure to meet this standard as verified by LDH will subject the Contractor to remediation outlined in Section 18 of this contract.	P/P for CM		Full	This requirement is addressed in Accessibility of Service and Care – Louisiana Coordinated System of Care UMCM 1 Policy and Standard.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.1.3	The Contractor shall develop and implement a care management program through a process which provides that clinically appropriate and cost-effective behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon clinically appropriate and cost-effective service plan that meets the behavioral health needs of the member.	P/P for CM		Full	This requirement is addressed in the CANS (Child Adolescent Needs and Strengths Comprehensive) and IBHA (Independent Behavioral Health Assessment) Procedure; Reviewing POC (Plan of Care) Procedure; Care Coordination General, Medicaid, Care Coordination Policy; and CSoC Plan of Care.	
7.1.4	Care Management program functions shall include but not be limited to, all of which must be addressed in the Contractor's Care Management policies and procedures:					
7.1.4.1	Early identification of members who have or may have special needs. For enrollees with special health care needs determined through an assessment to need a course of treatment, Contractor shall have in place a mechanism in place to directly access a specialist as appropriate for the enrollee's condition and identified needs in accordance with 42 CFR §438.208;	P/P for assessment of members Member's assessment tools		Full	This requirement is addressed in the Breaking Barriers Rounds Procedure and Information Exchange Procedure.	
7.1.4.2	Assessment of a member's current health status, risks, current service utilization and gaps in care initially and on an ongoing basis to ensure member health and safety using the required CANS and IBHA, and as appropriate, other assessment tools as deemed appropriate by the Contractor or required by LDH;	P/P for assessment of members Member's assessment tools File Review		Full	This requirement is addressed in the CANS (Child Adolescent Needs and Strengths Comprehensive) and IBHA (Independent Behavioral Health Assessment) Procedure. **File Review Results: CM** Twenty (20) of 20 CM files reviewed were compliant. **File Review Results**: **UM** Fifteen (15) of 15	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 Files reviewed were compliant.	
7.1.4.3 7.1.4.3.1 7.1.4.3.2 7.1.4.3.3 7.1.4.3.4 7.1.4.3.5	Development of an individualized comprehensive plan of care by the Wraparound Facilitator which must be in compliance with applicable federal waiver requirements, based on the results of the member's individual assessment and System of Care principles and values, and shared timely with service providers. The Wraparound Facilitator shall collaborate with the member and his/her family to identify who should be involved in the plan of care planning process and develop and implement the plan through a person-centered process by which the member and his/her family has a primary role. The plan of care must include the following elements at a minimum: 1. Member demographics; 2. Identification of the member's providers; 3. Member's goals, identified strengths and needs, and identified barriers to treatment; 4. Supports and services, including type, frequency, amount and duration needed to meet the member's needs; and 5. Plan for addressing crisis to prevent unnecessary hospitalization, incarceration, or out-of-home placement. The crisis plan must identify resources and contact information.	P/P for development of individualized plan of care P/P for coordination of services Example plan of care Onsite review of plan of care File Review		Full	This requirement is addressed in the POC Review Procedure under Standards and CSoC Review Report POC.	
7.1.4.4	Documentation that freedom of choice of services and providers were offered to the member and his/her caregiver by the Wraparound Facilitator;	P/P for provision of freedom of choice documentation Example of this communication		Full	This requirement is addressed in CSoC FOC (Freedom of Choice) and the Medicaid Care Coordination Policy.	
7.1.4.5	Referrals and assistance to ensure timely access to	Evidence of timely access		Full	This requirement is addressed in the	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	providers;				Accessibility of Service and Care Policy.	
7.1.4.6	Care coordination that actively linking members to providers, and coordinating with medical services, residential, social, community and other support services where needed;	P/P for coordination of services		Full	This requirement is addressed in the UMCM 12 Contacting Guardian or Youth Procedure, Care Coordination Continuity of Care, and Care Transition Workflow.	
7.1.4.7	Monitoring to identify early changes in the health status of members, ensure members are receiving needed services and supports, and ensure member progress and safety;	P/P for CM Evidence of monitoring File Review		Full	This requirement is addressed in the Health Status and Medical Needs Procedure and on-site UMCM 20.	
7.1.4.8	Continuity of care, including managing transitions between levels of care;	P/P for continuity of care P/P for transition of care		Full	This requirement is addressed in the Follow-up After Hospitalization Procedure and on-site UMCM 19.	
7.1.4.9	Timely follow-up for members who miss appointments or who are discharged from a 24-hour facility; and	Evidence of timely follow up		Full	This requirement is addressed in the Follow-up After Hospitalization Procedure and on-site UMCM 19.	
7.1.4.10 7.1.4.10.1 7.1.4.10.2	Developing and implementing strategies to reduce risk to members and families/caretakers or legal guardians, including, at a minimum: .1 Identifying members who are in need of more intensive monitoring or support, or that have high-risk needs that have not been addressed. .2 Offering alternative services when requested services are denied when appropriate.	P/P for strategies to reduce risk P/P for provision of freedom of choice documentation		Full	This requirement is addressed in the Breaking Barriers Rounds Procedure, Reviewing CANS & IBHA Procedure and Workflow, and assessment tool.	
7.1.4.11	Collaborating with the appropriate WAA to review members' individual plan of care and adjust services to address over reliance on crisis, ER or inpatient services.	P/P for Coordination of services		Full	This requirement is addressed in the Breaking Barriers Rounds Procedure and Care Coordination with ER.	
7.1.4.12	Documentation of care management activities on an individual member level.	P/P for documentation of care management activities		Full	This requirement is addressed in the Breaking Barriers Rounds Procedure, Workflows-Care Coordination with ER, Care Coordination with Agency Involvement, Care Coordination General, Contacting Guardian	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 Youth, and When Return to Home Setting is Not Possible.	
7.2	**Care Coordination, Continuity of Care, and Care Transition**					
7.2.1	The Contractor shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a holistic approach to providing behavioral healthcare services for all CSoC members. and shall coordinate the delivery of behavioral health services and care with the primary care services or other services that are provided under the Integrated Medicaid Managed Care Program or Fee for Service Medicaid (or other PAHP, PAHP or MCO if applicable)..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 activities shall be demonstrated via work flows with specific decision points, and included in the Contractor's Care Management policies and procedures.	P/P for Care Coordination P/P for continuity of care P/P for care transitioning		Full	This requirement is addressed in Care Coordination General, Primary Care (PCP) and Release of Information (ROI), Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.2	Continuity of care activities shall provide processes by which members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The Contractor shall ensure that service delivery is properly monitored through member surveys, treatment record reviews and Explanation of Benefits (EOB) to identify and overcome barriers to care that a member may encounter. Corrective action shall be undertaken by the Contractor on an as needed basis and as determined by LDH.	P/P for Continuity of Care		Full	This requirement is addressed in the Member Verification of Services Provided to Members Policy.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.2.3	The Contractor shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208.	P/P for Coordination of Care P/P for Continuity of Care		Full	This requirement is addressed in Care Coordination General, Care Coordination with Agency Involvement, Care Coordination with Inpatient Psychiatric or Detox Facility, Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.4	The Contractor is responsible for pursuing coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the I/DD co-occurring population.	P/P for Coordination of Care		Full	This requirement is addressed in UMCM 16-Dual OCDD/CSoC Eligibility – descriptions of various waivers, Eligibility Procedure, Care Coordination, and Care Transition workflows.	
7.2.5	The Contractor shall implement care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
7.2.5.1	Ensure that each member has an ongoing source of care appropriate to their needs;	P/P for Coordination of Care P/P for Continuity of Care		Full	This requirement is addressed in the Care Coordination General, Care Coordination Continuity of Care, and Care Transition workflows, and Medicaid Care Coordination Policy.	
7.2.5.2	Ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member. The Contractor shall document the individual's PCP in the care management record, or if none, follow-up on the PCP referral as part of the ongoing care management process. The Contractor shall attempt to obtain signature for release of information from the member or the family/caregiver or legal guardian, as appropriate, to coordinate care with the PCP and other	P/P for Coordination of Care P/P for Continuity of Care P/P for documentation in CM records P/P for protection of privacy File Review		Full	This requirement is addressed in Primary Care Physician (PCP) and Release of Information (ROI). **File Review Results: CM** Twenty (20) of 20 CM files reviewed were compliant.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	healthcare providers. If the member refuses consent, that shall be documented.					
7.2.5.4	Ensure the WAA will provide quick access to Wraparound care coordination. It is expected that the WAA will attempt to contact the youth/family within forty-eight (48) hours of the date of referral to the WAA. This will be measured through documentation on the monthly CSoC data spreadsheet. The WAA staff will make face-to-face contact with the youth/family within seven (7) calendar days of WAA referral, which will be tracked through the CSoC data spreadsheet or as required in the CSoC Quality Improvement Strategy (QIS).	P/P for Coordination of Care P/P for Continuity of Care Monthly CSoC data spreadsheet		Full	This requirement is addressed in the Data Spreadsheet (Pivot tables, data dictionary, summary of changes), and Referral Workflow (diagram).	
7.2.5.5	Coordinate care for out-of-network services;	P/P for Coordination of Care		Full	This requirement is addressed in the Ad Hoc Agreement Procedure and Coordination of Care.	
7.2.5.6	Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.	P/P for Coordination of Care		Full	This requirement is addressed in the Medicaid Care Coordination Policy, Care Coordination General-UMCM 5, Primary Care Physician (PCP) and Release of Information (ROI), Care Coordination Continuity of Care-Diagram, and Care Transition Workflow–Diagram.	
7.2.5.7	Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an inpatient, PRTF, nursing facility, or other residential stay for members when a return to home placement is not possible.	P/P for Coordination of Care File Review		Full	This requirement is addressed in Workflows and the Medicaid Care Coordination Policy, Case Management Rounds, PRTF-TGH Setting on Referral Date, Special Considerations for Youth in PRTF at Time of Referral-UMCM 39, Care Coordination Continuity of Care, When Return to Home Setting is Not Possible. **File Review Results: CM** Twenty (20) of 20 CM files reviewed were	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					compliant.	
7.2.5.8	Share with other healthcare entities serving the member the assessment, results and other information necessary to prevent duplication of activities.	P/P for Coordination of Care		Full	This requirement is addressed in the Medicaid Care Coordination Policy.	
7.2.5.9	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 42 CFR Part 2, 45 CFR Parts 160 and 164, and other applicable state or federal laws.	P/P for Coordination of Care P/P for protection of privacy		Full	This requirement is addressed in the Medicaid Care Coordination Policy, PR-BA Oral and Written Transmission of PHI, and Confidential Information Policy.	
7.2.5.10 7.2.5.10.1 7.2.5.10.2 7.2.5.10.3 7.2.5.10.4 7.2.5.10.5 7.2.5.10.6	Maintain and operate a formalized discharge planning program, including planning for discharges against medical advice. 1. Provide information to members regarding walk-in clinics and crisis services prior to discharge from a facility providing 24-hour levels of care. 2. Expedite approval of services for members being discharged from a 24-hour facility. 3. Ensure the discharge planning process is initiated at admission and finalized at least twenty-four (24) hours before the scheduled discharge. 4. Coordinate discharge and transition of members in an 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. 5. Ensure members receive follow-up appointment within seventy-two (72) hours with the appropriate behavioral	P/P for discharge planning File Review		Full	This requirement is addressed in the Initial Inpatient Psychiatric Review, Concurrent Inpatient Psychiatric Review-UMCM 23, Initial SUD Detox Review-UMCM 24, Concurrent SUD Detox Review-UMCM10, Follow-up After Hospitalization, Care Coordination with ER, Care Coordination Continuity of Care, and Care Transition workflows.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 provider following discharge. 6. Follow-up with members who are discharged from facilities providing 24-hour levels of care within seventy-two (72) hours post-discharge to ensure access to and attendance at aftercare appointments.					
7.2.5.11	Identify members using emergency department (ED) and inpatient psychiatric services inappropriately to assist in scheduling follow-up care with appropriate providers.	P/P for identifying member inappropriately using ED and inpatient psychiatric services		Full	This requirement is addressed in the Care Coordination General, Care Coordination with ER, Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.5.12	Provide active assistance to members receiving treatment for behavioral health conditions to transition to another provider when their current provider has terminated participation with the Contractor. The Contractor shall provide continuation of such services for at least ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.	P/P for transition of care		Full	This requirement is addressed in the Provider is Leaving the Network Procedure.	
7.2.5.13	Refer members to appropriate network providers and/or community resources offering tobacco cessation treatment and/or problem gaming services, if the Contractor becomes aware of problem gaming and tobacco usage during an individual needs assessment or case review.	P/P for referral to offering tobacco cessation treatment and/or problem gaming services		Full	This requirement is addressed in the Reviewing CANS & IBHA Procedure and Workflow Tobacco Cessation, and Problem Gaming Network Providers.	
7.2.5.14	Document referrals in Contractor's system.	Onsite review of Contractor's system		Full	This requirement is addressed in the Care Coordination General, Receiving Referral Call from HLP Procedure, Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.6	Coordination with the Integrated Medicaid Managed Care Plans					

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.2.6.1 7.2.6.1.1 7.2.6.1.2	The Contractor shall coordinate care with the member's Integrated Medicaid Managed Care Program Plan to promote overall health and wellness, including: 1. Coordination of services the Contractor furnishes to the member with the services the member receives through the Integrated Medicaid Managed Care Program including access to pharmacy needs. 2. Timely sharing of clinical information relative to the member's needs with Integrated Medicaid Managed Care Program Plan in order to prevent duplication of activities.	P/P for Coordination of Care Evidence of timely sharing of relevant information File Review		Full	This requirement is addressed in Workflows and the Care Coordination General, Health Status and Medical Needs Procedure, Referral to IMMCP Liaison Procedure, Primary Care Physician (PCP) and Release of Information (ROI) Information Exchange Procedure, Case Management Rounds, and Care Coordination Continuity of Care and Care Transition workflows.	
7.2.6.2 7.2.6.2.1 7.2.6.2.2 7.2.6.2.3	The Contractor shall support the integration of physical and behavioral health services and will work in conjunction with the Integrated Medicaid Managed Care Program. 1. The Contractor shall coordinate care for members with both medical and behavioral health disorders, including care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders. 2. The Contractor shall assist members with a newly diagnosed chronic medical disorder, who would benefit from psychosocial guidance. 3. The Contractor shall communicate and consult with PCPs and/or Integrated Medicaid Managed Care Program plan on co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.	P/P for Coordination of Care P/P for integration of physical and behavioral health services		Full	This requirement is addressed in the Care Coordination General, Health Status and Medical Needs Procedure, Referral to IMMCP Liaison Procedure, Primary Care Physician (PCP) and Release of Information (ROI) Information Exchange Procedure, and Case Management Rounds, Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.6.3 7.2.6.3.1 7.2.6.3.2 7.2.6.3.3	The Contractor shall implement measures that ensure effective co-management and information sharing between Integrated Medicaid Managed Care Program Plans and the Contractor, including:	P/P for Coordination of Care Educational materials related to appropriate ER		Full	This requirement is addressed in the Accessibility of Service and Care Policy, Care Coordination General, Health Status and Medical Needs Procedure, Referral to	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	1. Educating members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, when available and appropriate; .2. Identifying members who use emergency department (ED) services for specialized behavioral health needs to assist in scheduling follow-up care with appropriate behavioral health specialists; and .3. Ensuring referral, 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 medical services.	utilization P/P for referral to services P/P for Continuity of Care			IMMCP Liaison Procedure, Primary Care Physician (PCP) and Release of Information (ROI) Information Exchange Procedure, and Case Management Rounds, PRTF-TGH Setting on Referral Date, Special Considerations for Youth in PRTF at Time of Referral, Care Coordination Continuity of Care, and Care Transition workflows.	
7.2.6.4	The Contractor and the Integrated Medicaid Managed Care Program Plans shall work together to develop a single process for bidirectional information exchange related to shared members. The process will delineate the necessary information to be exchanged, timelines for information exchange, events and conditions that will trigger information exchange, data sharing format(s) and Information Technology (IT) requirements. The process and any changes to the process must be approved by LDH prior to implementation.	P/P for Coordination of Care P/P for information exchange Evidence of LDH approval		Full	This requirement is addressed in the Information Exchange –UMCM 22.	
7.2.6.5 7.2.6.5.1 7.2.6.5.2 7.2.6.5.3	The Contractor shall accept transferred calls as a seamless "warm transfer" from the Integrated Medicaid Managed Care Program Plans when members are identified as potentially eligible for	P/P for "warm transfer" of calls Call script P/P for referrals		Full	This requirement is addressed in the CSoC Referral Call from HLP (Healthy Louisiana Plan) Procedure, Referral Workflow.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	CSoC and apply the Brief Child and Adolescent Needs and Strengths (CANS) assessment tool to assess for CSoC presumptive eligibility. Upon completion of the Brief CANS before the call is terminated, the Contractor Care Manager shall inform the caller of the child/youth's CSoC eligibility status. 1. If the child/youth is presumptively eligible for CSoC and agrees to be referred, the Contractor Care Manager will make referrals for CSoC assessment and enrollment. 2. If the child/youth is presumptively eligible for CSoC and does not agree to be referred, the Contractor Care Manager will transfer the caller back to the member's Integrated Medicaid Managed Care Program Plan using a seamless "warm transfer." 3. If the child/youth is not presumptively eligible for CSoC, the Contractor Care Manager will transfer the caller back to the member's Integrated Medicaid Managed Care Program Plan using a seamless "warm transfer."					
7.2.6.6	The Contractor shall document the following information in the child's health record for Contractor's management system: the date of referral, Brief CANS results, date of referral to the Wraparound Agency (WAA) and Family Support Organization (FSO), date and result of Comprehensive CANS, date the Freedom of Choice (FOC) was signed or declined, reason given if FOC is declined.	P/P for health record documentation requirements File Review		Full	This requirement is addressed in the CANS & IBHA Procedure and Workflow, assessment tool, and Receiving a CSoC Referral Call from HLP (Healthy Louisiana Plan). **File Review Results: CM** Twenty (20) of 20 CM files reviewed were compliant.	
7.2.6.7	The Contractor Care Managers shall utilize secure email to provide notice to referring Integrated Medicaid Managed Care Program Plan Care Manager that information was received, and will	P/P for utilization of secure email		Full	This requirement is addressed in the Referral Workflow, PR-BA Oral and Written Transmission of PHI and Confidential Information Policy.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	contact the Integrated Medicaid Managed Care Program Plan Care Manager within three (3) business days of receipt of referral for routine referrals and within one business day, if referral is marked "urgent;"	File Review			**File Review Results: CM** Twenty (20) of 20 CM files reviewed were compliant.	
7.2.6.8	The Contractor shall document the member's PCP in the Care Management record or, if none, follow up on the PCP referral as part of the ongoing care management process, thus ensuring that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the healthcare services furnished to the member;	P/P for CM P/P for CM record documentation requirements File Review		Full	The requirement is addressed in the Information Exchange, Primary Care Physician (PCP) and Release of Information, Referral to IMCP (Integrated Medicaid Managed Care Program) Liaison, Health Status and Medical Needs Procedure. **File Review Results: CM** Twenty (20) of 20 CM files reviewed were compliant.	
7.2.6.9	The Contractor shall distribute Release of Information forms as per 42 CFR §431.306, and provide training to Contractor providers on its use;	P/P and evidence of distribution of Release of Information forms Training materials and associated sign-in sheets		Full	The requirement is addressed in the Provider Release of Information, Primary Care Physician (PCP) and UMCM 32 Release of Information (ROI) Procedure. On-site, MCO provided the website (www.magellan of Louisiana.com), provider handbook, and quarterly All Provider Call.	
7.2.6.10	The Contractor shall conduct Case Management rounds at least monthly with each Integrated Medicaid Managed Care Program plan;	P/P for CM rounds		Full	This requirement is addressed in the Case Management Rounds, Information Exchange and CM Rounds Minutes and Attendance Rosters.	
7.2.7	When the Contractor becomes aware that a child/youth will be discharged or disenrolled from CSoC, the Contractor shall notify the member's Integrated Medicaid Managed Care Program Contractor that a youth will be disenrolled from CSoC, and shall coordinate discharge planning with the Integrated Medicaid Managed Care Program Contractor to ensure smooth transition	P/P for discharge procedures		Full	This requirement is addressed in Workflows and the Discharge Coordination of Care, Completing Discharge from CSoC, and Case Management Rounds.	

Care Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 care management of specialized behavioral healthcare services, such that the youth's specialized behavioral healthcare needs will be transitioned seamlessly from management by the CSoC Contractor to management by the Integrated Medicaid Managed Care Program Contractor. Contractor shall provide the results to the Integrated Medicaid Managed Care Program Contractor of the initial comprehensive CANS assessment, IBHA, most recent POC (which includes crisis plan), and the discharging or most recent comprehensive CANS assessment, and any other assessments conducted during the CSoC enrollment.					
7.3	**Care Management Policies and Procedures**					
7.2.1	The Contractor shall submit Care Management Program policies and procedures to LDH for approval within thirty (30) days from DOA/OSP approval of signed contract, and prior to any revisions.	Evidence of timely submission		Full	This requirement is addressed by the timely submission of Case Management Program Policies and Procedures.	

Utilization Management

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.4	**Utilization Management**					
7.4.1	Utilization Management (UM) is the component of care management that evaluates the medical necessity of healthcare services according to established criteria and practice guidelines to ensure the right amount of services are provided when the member needs them. UM also focuses on individual and system outliers that require review to assess if individual members are meeting their goals and if service utilization across the system is meeting the goals for delivery of community-based services.					
7.4.2	The Contractor shall implement a UM program that has sufficient LMHPs, including Licensed Addiction Counselors (LACs), as well as a board certified psychiatrist. The other LMHPs shall be available twenty-four (24) hours per day, seven (7) days per week. The Contractor shall provide UM staff experienced and specifically assigned to children and youth.	P/P for addiction treatment training Training materials for addiction treatment training and associated sign-in sheets Evidence of service capacity		Full	This requirement is addressed in UM Staffing regarding mix of LMHP (licensed mental health practitioners), LAC (licensed addiction counselors), clinicians with SUD (substance use disorders), D/D (developmental disabilities) Accessibility of Service and Care Policy. Additional information was provided on-site regarding staff.	
7.4.2.1	The Contractor will commit to having sufficient staff knowledgeable of and trained in addictions treatment to assist members with addiction treatment needs.	P/P for addiction treatment training Training materials for addiction treatment training and associated sign-in sheets		Full	This requirement is addressed in UM Staffing UMCM 42. Additional information was provided on-site regarding training meetings minutes and attendance rosters.	
7.4.2.2	The Contractor will commit to having sufficient staff knowledgeable of and trained in intellectual and developmental disabilities to assist members with I/DD needs.	P/P for addiction treatment training Training materials for addiction treatment training and associated sign-in sheets		Full	This requirement is addressed in UM Staffing UMCM 42 and training meetings and attendance rosters.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.4.3	The Contractor shall develop and maintain policies and procedures with defined structures and processes for a UM program that incorporates Utilization Review and Service Authorization. The Contractor shall submit UM policies and procedures within thirty (30) days from the date the contract is signed and approved by DOA/OSP to LDH for written approval, annually by contract year thereafter, and prior to any revisions.	P/P for addiction treatment training Evidence of timely submission to LDH		Full	This requirement is addressed in the UM Program Description.	.
7.4.5 7.4.5.1 7.4.5.2 7.4.5.3 7.4.5.4	The Contractor's UM program shall comply with federal utilization control requirements, including the certification of need and recertification of need for continued stay inpatient settings. The Contractor shall require inpatient hospitals to comply with federal requirements regarding utilization review plans, utilization review committees, plans of care, and medical care evaluation studies as prescribed in 42 CFR Parts 441 and 456. The Contractor shall actively monitor UM activities for compliance with federal, state, and LDH requirements. The UM Program policies and procedures shall meet the NCQA standards and include medical management criteria and practice guidelines that: 1. Are adopted in consultation with a contracting healthcare professional; 2. Are objective and based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; 3. Consider the needs of the members; and 4. Are reviewed annually and updated periodically as appropriate.	P/P for UM program P/P for UM monitoring		Full	This requirement is addressed in the UM Program Policy, Benefit Certification and Appeal General Guidelines, Clinical Practice Guidelines Development and Review, Medicaid Service Authorization Determination, Non-authorized Lack of Participation in UM Process, Louisiana CSoC Medical Necessity Criteria, Utilization Management Committee, and Utilization Management General Guidelines, Behavioral Health Supplement.	
7.4.6 7.4.6.1 7.4.6.2	The policies and procedures shall include, but not be limited to: 1. The methodology utilized to grant service	P/P for UM program		Full	This requirement is addressed in the UM Program Policy, Initial Inpatient Psychiatric Review, Initial SUD Detox Review,	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.4.6.3 7.4.6.4 7.4.6.5 7.4.6.6 7.4.6.7 7.4.6.8 7.4.6.9 7.4.6.10 7.4.6.11	authorization based on medical necessity, appropriateness, efficacy, or efficiency of healthcare services and in accordance with waiver and state requirements; 2. The data sources and clinical review criteria used in decision making; 3. Required documentation for the clinical review process; 4. Mechanisms to ensure consistent application of review criteria and compatible decisions; 5. Data collection processes and analytical methods used in assessing utilization of healthcare services; 6. Provisions for assuring confidentiality of clinical and proprietary information in accordance with 42 CFR §438.224; 7. A mechanism for monitoring members' utilization of behavioral health services to ensure Title XIX and Title XXI reimbursement is not made beyond the service limitations specified in Section 4 for Covered Benefits and Services; 8. Addressing the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the Contractor may deny authorization of the requested service(s); .1 Providing the WAA and contracted service providers with technical assistance regarding UM policies and procedures and the application of services authorization criteria and practice guidelines; .2 Assisting the WAA with specialized training to				Concurrent Inpatient Psychiatric Review, Concurrent SUD Detox Review, Plan of Care Review, Physician Advisor Review, Non-authorized Lack of Participation in UM Process, Title XIX & XXI Service Limitations, Utilization Management General Guidelines, Behavioral Health Supplement, Member Authorization Request, WAA Training and Support, and WAA Coordinators Job Description and Duties.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	develop and manage sustainable Plans of Care, consistent with UM policies and procedures; **.3** Providing a mechanism in which a member may submit, whether verbally 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.					
7.4.7 7.4.7.1 7.4.7.2 7.4.7.3	The Contractor shall develop and disseminate clinical practice guidelines (CPGs) to all providers as appropriate and, upon request, to members and potential members in accordance with 42 CFR §438.236 and this contract. 1. At a minimum, the Contractor shall develop CPGs for Attention Deficit Hyperactivity Disorder, Trauma Informed Care, Depression and Conduct Disorder. These CPGs must be submitted to LDH for approval within thirty (30) days of contract execution and upon revision. 2. The Contractor shall develop additional CPGs based on analysis of prevalent diagnosis of the population, relative benefit on clinical outcomes, or relative benefit on cost-effectiveness. The Contractor shall submit the proposed clinical guidelines and analysis to LDH for approval within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines. 3. The Contractor shall require the adoption of the relevant CPGs by providers based on their practice.	CPGs Evidence of dissemination P/P for implementation of CPGs		Full	This requirement is addressed in the Clinical Practice Guidelines Development and Review Policy, Plan of Care Review, Plan of Care Review Tool, CPG – ADHD, CPG – Depression Introduction, Conduct Disorder Practice Parameter, Trauma Practice Parameter AACAP, 12.6 Treatment Record Review Procedure, and 12.6 Magellan of Louisiana CSoC Provider Monitoring Review Tools.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.4.8 7.4.8.1 7.4.8.2	The Contractor shall have staff with clinical expertise and training to apply service authorization criteria, including but not limited to the application of the CANS algorithm to determine clinical eligibility, based on medical necessity and practice guidelines. Determinations of service authorization must be made by qualified and trained LMHPs in accordance with state and federal regulations. 1 The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the reviewer's physical, mental, professional or moral character. 2 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 staff requirements <u>File Review</u>		Full	This requirement is addressed in the UM Staffing, and additional information in the New Hire Agenda. **File Review Results**: Fifteen (15) of 15 UM denial files reviewed were compliant. **<u>Recommendation:</u>** The PAHP should specify licensed mental health professionals' role in denials is for eligibility and administrative matters only.	Magellan's procedure will be updated to include IPRO's recommendation. The revision will be sent to the LDH for approval by 8/31/19.
7.4.9	The Contractor shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for service authorization determinations. The Contractor shall make service authorization determinations that are consistent with the State's definition of medical necessity.	P/P for service authorization determinations		Full	This requirement is addressed in the UM Program Policy.	
7.4.10	The Contractor shall provide a mechanism to reduce inappropriate and duplicative use of behavioral healthcare services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose	P/P for scope of services		Full	This requirement is addressed the in UM Program Policy.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 which the services are furnished. The Contractor 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.					
7.4.12 7.4.12.1 7.4.12.2 7.4.12.3 7.4.12.4 7.4.12.5 7.4.12.6	In accordance with 42 CFR §456.111 and §456.211, the Contractor Utilization Review plan must provide that each member's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following: 1. Identification of the member; 2. The name of the member's provider; 3. If in a facility, the date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission; 4. The POC required under 42 CFR §456.80 and §456.180; 5. If in a facility, initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133; §456.233 and §456.234; and 6. Justification of emergency admission, if applicable.	UR Plan P/P for UR		Full	This requirement is addressed in the Member Record Minimum Requirements.	
7.5	**Service Authorization**					
7.5.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.					
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3 7.5.2.4	The Contractor UM Program policies and procedures shall include service authorization policies and procedures consistent with the State Plan, SPAs, and 1915(b) and 1915(c) waivers, 42 CFR §438.210, and state laws and regulations for	P/P for UM P/P for service authorization File Review		Full	This requirement is addressed in the UM Program Policy, Benefit Certification and Appeal General Guidelines, Clinical Practice Guidelines Development and Review, Medicaid Service Authorization	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
7.5.2.5 7.5.2.6	initial and continuing authorization include, but are not limited to, the following: 1. Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization is for the provision of a service if a provider refuses a service or does not request a service in a timely manner; 2. Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate; 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 healthcare professional who has appropriate clinical expertise in treating the member's condition and shall be submitted by the Contractor to the provider and member in writing; 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 the Contractor's member manual and incorporated in the grievance procedures; 5. The Contractor's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and 6. The Contractor's service authorization system shall electronically store and report all service authorization requests, decisions made by the				Determination, Non-authorized Lack of Participation in UM Process, Louisiana CSoC Medical Necessity Criteria, Utilization Management Committee, Utilization Management General Guidelines, Behavioral Health Supplement, Authorization of Verbal Notice and Documentation Procedure, Plan of Care Review, Physician Advisor Review, and IRR POC Review Tool. **File Review Results:** Fifteen (15) of 15 UM denial files reviewed were compliant.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	Contractor regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.					
7.5.3	For all modalities of care, the amount, duration or scope of treatment should be determined by the member's needs and his or her response to treatment. Note: In the absence of medical necessity, Medicaid cannot be the payment source for these services.			Full	This requirement is addressed in the UM Program Policy.	
7.6	**Utilization Management (UM) Committee**					
7.6.1	The UM program shall include a UM Committee that integrates with other functional units of the Contractor as appropriate and supports the Quality Assessment and Performance Improvement (QAPI) Program (refer to the Quality Management subsection for details regarding the QAPI Program).					
7.6.2 7.6.2.1 7.6.2.2 7.6.2.3 7.6.2.4 7.6.2.5 7.6.2.6 7.6.2.7 7.6.2.8 7.6.2.9	The UM Committee shall provide utilization review and monitoring of UM activities of both the Contractor and its providers and is directed by the Contractor CMO. The UM Committee shall convene no less than quarterly and shall submit the meeting agenda, sign-in sheets, handouts and presentations, and minutes to LDH within five (5) business days of each meeting. If minutes are not approved within five (5) business days after meeting, minutes must be submitted within five (5) business days of final approval or draft minutes will be submitted within two (2) weeks of meeting, whichever is sooner. LDH shall be invited to attend the UM committee meetings. UM Committee responsibilities include: 1. Monitoring providers' requests for PAs;	P/P for UM Committee Agendas and Minutes of UM Committee Meetings		Full	This requirement is addressed in the Utilization Management Committee UMCM 43 Procedure. Additional information provided regarding UM Committee Meeting Minutes and attendance rosters.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	2. Monitoring the medical appropriateness and necessity of services provided to its members utilizing provider quality and utilization profiling; 3. Reviewing the effectiveness of the utilization review process and making changes to the process as needed; 4. Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task; 5. Monitoring consistent application of service authorization criteria to determine medical necessity; 6. Monitoring of the application of clinical practice guidelines; 7. Monitoring over- and under-utilization; 8. Review of outliers; and 9. Monitoring of Treatment Record Review (TRR) process.					
7.7	**Utilization Management (UM) Reports**					
7.7.1	The Contractor shall submit UM reports as specified by LDH. LDH reserves the right to request additional reports as deemed by LDH.	P/P for submission of UM reports		Full	This requirement is addressed in the Utilization Management Committee Procedure, which states that UM Committee convenes quarterly, has sign-in sheets and agenda, which must be submitted to LDH. UM Meeting Minutes and attendance rosters provided.	
7.7.2	The Contractor shall actively monitor and analyze utilization and cost data for covered behavioral health services, including by provider type. The Contractor shall report complete and accurate utilization data to LDH in a manner and format prior approved by LDH.	P/P for UM		Full	This requirement is addressed in the Utilization Management Committee Procedure.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8	**Timing of Service Authorization Decisions**					
7.8.1	There shall be twenty-four (24)-hour, seven (7) days per week, three hundred and sixty-five (365) days per year capacity for service authorization by LMHP care managers.	P/P for service authorization		Full	This requirement is addressed in the Accessibility of Service and Care Policy UMCM 1 Policy Standards.	
7.8.2 7.8.2.1 7.8.2.2 7.8.2.3 7.8.2.4	Standard Service Authorization 1. As per 42 CFR §438.210(d), the Contractor shall provide notice as expeditiously as the member's health condition requires and within state-established timeframes that may not exceed fourteen (14) calendar days following receipt of the request for service unless an extension is requested. As per the 1915(b) waiver and 42 CFR §438.206, the Contractor shall ensure its providers meet established standards for timely access to care and services, taking into account the urgency of the need for services. 2. An extension may be granted for service authorization determination for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the Contractor justifies to LDH, upon request, a need for additional information and the extension for service authorization determination is in the member's best interest. In no instance shall any determination of standard service authorization be made later than twenty-eight (28) calendar days from receipt of the request. 3. The Contractor shall make concurrent review determinations within timeframes established under NCQA for each LOC after obtaining the appropriate medical information that may be	P/P for service authorization File Review		Full	This requirement is addressed in Timing of Service Authorization Decisions Procedure UMCM 40. **File Review Results:** Fifteen (15) of 15 UM denial files reviewed were compliant.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	required. **4.** The Contractor shall create a quarterly report on standard service authorizations and denials in a format to be approved by LDH. Changes in the frequency and format of this report shall be upon the approval and at the discretion of LDH.					
7.8.3 7.8.3.1 7.8.3.2 7.8.3.3	Expedited Service Authorization 1. In the event a provider indicates, or the Contractor 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 Contractor 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. 2. The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or Contractor justifies to LDH, upon request, a need for additional information and how the extension is in the member's best interest. **3.** The Contractor shall include in the quarterly report (see Section 16) expedited service authorizations and denials in a format to be approved by LDH. Changes in the frequency and format of this report shall be upon approval and at the discretion of LDH.	<u>P/P for Expedited Service Authorization</u> <u>File Review</u>		Full	This requirement is addressed in the Timing of Service Authorization Decisions Procedure UMCM 40. **File Review Results**: Fifteen (15) of 15 UM denial files reviewed were compliant.	
7.8.4 7.8.4.1 7.8.4.2	Post Authorization 1. The Contractor shall make retrospective review determinations within thirty (30) days of receipt of sufficient medical information	P/P for post authorization		Full	This requirement is addressed in the Timing of Service Authorization Decisions Procedure UMCM 40.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	necessary to make a determination Retrospective review determinations shall be completed within one hundred eighty (180) days from the date of service. **2.** The Contractor shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission, or the provider misrepresented the member's health condition.					
7.8.5 7.8.5.1	.1 Notice of Action					
7.8.5.2 7.8.5.2.1 7.8.5.2.2	Approval 1. For service authorization approval for a routine or non-urgent admission, procedure, or service, the Contractor shall make the determination for approval as expeditiously as the member's health condition requires (14 days for routine) but shall notify the provider within 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. **2.** For service authorization approval for extended stay or additional services, the Contractor shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service verbally as expeditiously as the member's condition requires, but not more than one (1) business day of making the initial	P/P for service authorization Includes File Review		Full	This requirement is addressed in the Timing of Service Authorization Decisions Procedure, Authorization Verbal Notice and Documentation Procedure.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial certification.					
7.8.5.3 7.8.5.3.1 7.8.5.3.2	1. Adverse Benefit Determination The Contractor shall notify the member in writing, using language that is easily understood at a fifth-grade reading level, of decisions and reasons 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 11 of this contract. The notice of adverse benefit determination to members shall be consistent with requirements in 42 CFR §438.404(a) and (c) and 42 CFR §438.210(b)(c)(d) for member written materials and any agreements that LDH may have entered into relative to the contents of enrollee notices or denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements. The notice shall contain information regarding the Contractor's grievance and appeals process.	P/P for Adverse Benefit Determination Includes File Review		Full	This requirement is addressed in the Physician Advisor Review, Nondiscrimination and Language Access Policy. **File Review Results:** Fifteen (15) of 15 UM denial files reviewed were compliant.	
7.8.5.3.2	The Contractor shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The Contractor shall notify the provider rendering the service, verbally as expeditiously as the member's health condition requires, but not more than one (1) business day	P/P for Adverse Benefit Determination Includes File Review		Full	This requirement is addressed in the Physician Advisor Review, Timing of Service Authorization Decisions Procedures. **File Reviews Results**: Fifteen (15) of 15 UM denial files reviewed were compliant.	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.					
7.8.5.4 7.8.5.4.1	Informal Reconsideration As part of the Contractor Service Authorization process, the Contractor shall include an Informal Reconsideration process that allows the provider (on behalf of the member and with the member's written consent) a reasonable opportunity to present clinical information in writing or verbally to discuss a medical necessity denial with a physician or other appropriate reviewer.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Physician Advisor Review, Timing of Service Authorization Decisions Procedures.	
7.8.5.4.2	In a case involving an initial determination or a concurrent review determination, the Contractor shall provide the provider (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.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Physician Advisor Review, Timing of Service Authorization Decisions Procedures.	
7.8.5.4.3	The informal reconsideration shall occur within one (1) business day of the receipt of the request and should be conducted between the provider rendering the service and the Contractor's LHMP authorized to make adverse determinations or a clinical peer designated by the Contractor's Medical Director if the LMHP who made the adverse determination cannot be available within one (1) business day.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Physician Advisor Review, Timing of Service Authorization Decisions Procedures.	
7.8.5.5 7.8.5.5.1	Exceptions to Requirements The Contractor shall not require service authorization for emergency services.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Medicaid Emergency Service and Post-stabilization Services under Standards 1 and 2, Timing of Service Authorization Decisions	

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					Procedure UMCM 40.	
7.8.5.5.2	The Contractor shall not require service authorization or referral for EPSDT behavioral health screening services.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Medicaid Emergency Service and Post-stabilization Services under Standards 1 and 2, Timing of Service Authorization Decisions Procedure UMCM 40.	
7.9	**Documentation for Service Authorization**					
7.9.1	The Contractor is responsible for eliciting pertinent medical record information from the treating healthcare provider(s) as needed for purposes of making service authorization determinations based on medical necessity.	P/P for service authorization		Full	This requirement is addressed in the Initial Inpatient Psychiatric Review, Initial Inpatient SUD Detox Review, Concurrent Inpatient Psychiatric Review, Concurrent Inpatient SUD Detox Review, and POC Review.	
7.9.2	The Contractor shall take appropriate action when a treating healthcare provider does not cooperate with providing complete medical history information within the requested timeframe.	P/P for service authorization		Full	This requirement is addressed in the Non-authorized Lack of Participation in UM Process.	
7.9.3	The Contractor shall deny payment to providers who do not provide requested treatment record information for purposes of making medical necessity determinations, for a particular item or service, for the provision of such item or service.	P/P for service authorization		Full	This requirement is addressed in the Non-authorized Lack of Participation in UM Process.	
7.9.4	Should a provider fail or refuse to respond to the Contractor's request for medical record information, at the Contractor's discretion or directive by LDH, the Contractor shall, at a minimum, impose financial penalties against the provider as appropriate.	P/P for service authorization		Full	This requirement is addressed in the Non-authorized Lack of Participation in UM Process.	
7.10	**Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay**					
7.10.1	The Contractor shall subject all court-ordered					

Utilization Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	Medicaid behavioral health services to medical necessity review. In order to be eligible for payment, the service shall be medically necessary and a covered benefit/service, as determined by the Contractor within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.					
7.11	**Provider Utilization and Quality Profiling**					
7.11.1 7.11.1.1 7.11.1.2 7.11.1.3	The Contractor shall profile all its providers and analyze utilization data to identify provider utilization and quality of care issues. 1. The Contractor shall maintain a procedure to identify and evaluate member inpatient utilization; 2. The Contractor shall maintain a procedure to identify and evaluate member's hospital admission utilization; and 3. The Contractor shall establish individual provider clinical quality performance measures.	P/P for utilization data		Full	This requirement is addressed in the Utilization Management Committee, Provider Utilization and Quality Profile Report.	
7.11.2	The Contractor shall investigate and intervene, as appropriate, when utilization or quality of care issues are identified.	P/P for investigation/ intervention re: quality of care		Full	This requirement is addressed in the Provider Utilization and Quality Profile Report and on-site quality of care.	
7.12	**Provider Utilization & Quality Profile Reporting Requirements**					
7.12.1	The Contractor shall provide individual provider profiles or a comprehensive provider report upon request from LDH. LDH reserves the right to request additional reports as deemed necessary	P/P for provider profiles Evidence of LDH communication if applicable		Full	This requirement is addressed in the Provider Utilization and Quality Profile Report.	

Provider Services

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
9	**PROVIDER SERVICES**					
9.1	**Provider Relations**					
9.1.1	The Contractor shall, at a minimum, provide a provider relations function to provide support and assistance to all providers in the Contractor's network. The Contractor shall:					
9.1.1.1	Be available Monday through Friday from 8:00 a.m. to 4:30 p.m. Central Time to address non-emergency provider issues and on a 24/7 basis for urgent or emergency/crisis requests;	P/P for provider relations		Full	This requirement is addressed in the Annual Provider Training Plan, pages 3 and 6.	
9.1.1.2	Provide ongoing provider training, respond to provider inquiries and provide general assistance to providers regarding program operations and requirements; and	P/P for provider training Sample training materials Sing-in sheets		Full	This requirement is addressed in the Annual Provider Training Plan, page 6.	
9.1.1.3	Ensure visits as needed to provider sites, as well as ad hoc visits as circumstances dictate, including provider training and technical assistance. Documentation of these visits will be provided to LDH upon request and shall include sign-in sheets, agendas, documented follow-up action items (as appropriate), and any distributed materials. Materials are subject to LDH approval upon request and	P/P for provider site visits		Full	This requirement is addressed in the Annual Provider Training Plan and PAHP website.	
9.1.1.4	Staff and maintain a provider complaint system as detailed in Section 9.6.	P/P for provider complaint system		Full	This requirement is addressed in the Comment Process Policy and Standards and section 9.6 of this tool.	
9.1.2	The Contractor shall submit all provider informational materials and formal communications to LDH for written approval prior to distribution.					

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
9.2	**Provider Toll-free Telephone Line**					
9.2.1	The Contractor must operate a toll-free telephone line to respond to provider questions, comments and inquiries. The toll-free number may be the same number members use to contact the Contractor.					
9.2.2	The provider access component of the toll-free telephone line must be staffed between the hours of 8:00 a.m. – 4:30 p.m. Central Time Monday through Friday to respond to provider questions in all areas, including provider complaints and grievances and appeals on member's behalf and regarding provider responsibilities.	P/P for provider relations		Full	This requirement is addressed in the Accessibility of Service and Care – Louisiana Coordinated System of Care Policy and Standards, page 2.	
9.2.3 9.2.3.1 9.2.3.2 9.2.3.3 9.2.3.4 9.2.3.5 9.2.3.6	The Contractor's call center system must have the capability to track provider call management metrics, including: 1. Average speed to answer. 2. Separate call tracking and record keeping shall be established for track¬ing and monitoring provider and member phone lines. 3. Nature of calls. 4. Call abandonment rates which shall not exceed five percent (5%) daily. 5. The Contractor shall report call center metrics and outcomes to LDH upon request. 6. The toll-free number shall be submitted to LDH. The Contractor shall agree that LDH shall own the rights to the toll-free call center number. It is anticipated that this number will be transitioned to LDH at the end of the contract term.	P/P for provider relations		Full	This requirement is addressed in the Accessibility of Service and Care – Louisiana Coordinated System of Care Policy and Standards and on-site discussions with the PAHP.	
9.2.4	After normal business hours, the provider service component of the toll-free telephone line must include the capability of providing information	P/P for provider relations		Full	This requirement is addressed in the Accessibility of Service and Care – Louisiana Coordinated System of Care Policy and	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	regarding normal business hours and instructions to verify enrollment in Medicaid for any CSoC member with an emergency or urgent medical condition. This shall not be construed to mean that the provider must obtain verification before providing ED services and care.				Standards and on-site discussions with the PAHP.	
9.2.7	The Contractor shall physically locate the call center in Louisiana, with exceptions approved by LDH. Magellan also utilizes a virtual call center that supports afterhours and provider calls.			Full	This requirement is addressed in the Accessibility of Service and Care – Louisiana Coordinated System of Care Policy and Standards and on-site discussions with the PAHP.	
9.2.8	The provider call center shall have a language line translation system for callers whose primary language is not English (to at least include Spanish) and a TTY/TDD and/or relay system available. Both services shall be available twenty-four (24) hours per day, seven ((7) days per week, three hundred and sixty-vice (365) days per year.	P/P for provider relations		Full	This requirement is addressed in the Accessibility of Service and Care – Louisiana Coordinated System of Care Policy and Standards and on-site discussions with the PAHP.	
9.3	**Provider Website**					
9.3.1	The Contractor shall have a CSoC-dedicated provider website or web page as approved by LDH. The CSoC provider website shall contain both a public facing and secure provider portal which shall be a comprehensive, integrated, internet-based behavioral health management information system.	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/ and https://www.magellanprovider.com .	
9.3.2	The Contractor provider website shall include general and up-to-date information about the Contractor as it relates to the CSoC program. Any new materials posted on the website shall be approved by LDH. This shall include, but is not limited to:					
9.3.2.1	CSoC Provider manual;	Review of website		Full	This requirement is addressed in	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
					https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-handbook/.	
9.3.2.2	Contractor-relevant LDH bulletins;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/informational-bulletins/.	
9.3.2.3	Information on upcoming provider trainings;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/training-events/provider-training-requirements/.	
9.3.2.4	Information on the provider complaint, member grievance and appeal system;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-members/member-materials/grievances-appeals/ and https://www.magellanprovider.com/media/1625/csocsupp.pdf, page 32.	
9.3.2.5	Information on obtaining PA and referrals;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/become-a-member/how-to-make-a-referral/.	
9.3.2.6	Information on how to contact Contractor Provider Relations;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/network-management-specialists/.	
9.3.2.7	Information on all programs and services provided through the contract;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/media/4281/csoc_sop_11-2018-final.pdf and https://www.magellanoflouisiana.com/become-a-member/what-is-csoc/overview/.	
9.3.2.8	A provider directory;	Review of website		Full	This requirement is addressed in	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
					https://www.magellanoflouisiana.com/for-members/find-a-provider/.	
9.3.2.9	Emergency preparedness and disaster response contacts and instructions;	Review of website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-members/member-materials/member-resources/emergency-preparedness-current-events/.	
9.3.2.10	**Limitations on provider marketing; and**	**Review of website**		Non-compliance	This requirement is not addressed in the PAHP's website. **Recommendation:** The PAHP should address limitations on provider marketing on the PAHP's website.	Magellan will partner with the LDH to define provider marketing limitations during our CSoC Operations Meeting on 8/22/19. The website will be updated accordingly.
9.3.2.11	Information on requirements and reporting fraud, waste, and abuse.	Review of website		Full	This requirement is addressed in the PAHP's website.	
9.3.3	The Contractor provider portal shall provide the ability for the following actions/activities:	P/P for provider portal Review of portal				
9.3.3.1	Claims Payment;	P/P for provider portal Review of portal		Full	This requirement is addressed in Screen Shot #2 and https://www.magellanoflouisiana.com/media/4041/new-provider-orientation-final.pdf.	
9.3.3.2	Eligibility verification;	P/P for provider portal Review of portal		Full	This requirement is addressed in https://www.magellanoflouisiana.com/media/4041/new-provider-orientation-final.pdf.	
9.3.3.3	Interface with the Louisiana Medicaid program;	P/P for provider portal		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-members/member-materials/accessing-services/csoc-4-specialized-services/.	
9.3.3.4	Allow the provider access to member clinical data, with appropriate member consent, including	P/P for website		Full	This requirement is addressed in Member Data Access 9.3.3.4.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	assessments and Plans of Care and/or relevant data necessary to provide for appropriate coordination of care; and					
9.3.3.5	Provide online accessible methodology for providers to review and update staff rosters of credentialed and contracted providers of mental health rehabilitation services.	P/P for website		Full	This requirement is addressed in Screen Shot 3 9.3.3.5 Roster Updates.	
9.3.4	The Contractor must keep eligibility data accurate based on the daily feed from the Medicaid FI. Failure to keep systems accurate and up to date shall make the Contractor subject to any sanction which is authorized by the contract.	P/P for website Review of website		Full	This requirement is addressed in https://www.magellanprovider.com/MagellanProvider/do/LoadHome and in the provider handbook, pages 37 and 48.	
9.3.5	The provider website shall support claims processing and administration, membership management and services, provider network management (including provider profiling, outcomes, and quality of care information), care management, UM, and grievances and appeals.	P/P for website		Full	This requirement is addressed in Screen Shot 1 9.3.5 Provider Website and Screen Shot 2 9.3.5 Provider Website and website walkthrough while on site.	
9.3.6	The Contractor shall use current state and federal standards and procedures (e.g., HL7, HIPAA, CMS, CPT, ICD-10, DSM-5) for this system and will maintain a uniform service and provider (credentials) taxonomy for billing and information management purposes.	P/P for website		Full	This requirement is addressed in the PAHP's website.	
9.3.7	The Contractor shall provide online accessible methodology for providers to review and update staff rosters to include educational backgrounds and credentials. The Contractor shall ensure all providers are accurately loaded into their provider registry.	P/P for website Provider registry		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-handbook/ and Network Provider Data Maintenance and Data Integrity 9.3.7.	
9.3.8	The Contractor shall provide technical assistance and consultation to providers on establishing the means for effective, ongoing electronic collection	P/P for website		Full	This requirement is addressed in the Annual Provider Training Plan Final 9.3.8.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and transfer of required data.					
9.3.9	The Contractor shall be responsible for maintaining standardized data collection processes and procedures and provide training and support to all provider staff.	P/P for website data collection Example training materials		Full	This requirement is addressed in the Data Collection and Integration Procedure.	
9.3.10	The Contractor shall perform data quality management, in conjunction with LDH in order to ensure that the data are accurate, appropriate, complete, and timely reported.	P/P for QM Evidence of communication with LDH		Full	This requirement is addressed in the Quality Improvement Program, pages 5 to 6.	
9.3.11	The Contractor shall maintain disaster recovery and business continuity of this system, as well as the provisions for the State to have continued access to and use of these data in the event of a separation of service with the Contractor.	P/P for disruption of service		Full	This requirement is addressed in the Emergency Management Plan.	
9.3.12	Substantive changes to the website must be approved in writing by LDH.	Evidence of communication with LDH if applicable		Not applicable	Substantive changes to the website were not made during the review period.	
9.3.13	The Contractor must remain compliant with HIPAA privacy and security requirements when providing any member eligibility or member identification information on the website.	P/P for website P/P for HIPAA compliance		Full	This requirement is addressed in https://www.magellanoflouisiana.com/utility/privacy-policy/.	
9.3.14	The Contractor provider website should, at a minimum, be in compliance with Section 508 of the ADA, and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern.	P/P for website		Full	This requirement is addressed in Section 508 Refresh and Medicaid Accessibility.	
9.3.15	The Contractor shall grant user-defined LDH access to and training on the provider website. User access under this provision shall be determined by LDH.	P/P for LDH website access		Not applicable	The PAHP indicated that a request was not made during the review period.	
9.4	**Provider Handbook**					
9.4.1	The Contractor shall develop and issue for LDH	Provider Handbook		Full	This requirement is addressed in the LA CSoC	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	approval a CSoC specific provider handbook within thirty (30) days of the date the Contractor signs the contract with LDH. The Contractor may choose not to distribute the provider handbook via surface mail, provided the Contractor submits a written, mailed notification and an email notification to all providers that explains how to access the provider handbook from the Contractor's website. This notification shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding CSoC covered services, Contractor policies and procedures, state or federal statutes, regulations, telephone access and special requirements to ensure all provider requirements are met. At a minimum, the provider handbook shall include the following information:				Provider Handbook.	
9.4.1.1	Description of the Contractor and the CSoC program;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 5 to 6.	
9.4.1.2	Covered benefits and services;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 9.	
9.4.1.3	Emergency/Crisis service responsibilities;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 18.	
9.4.1.4	Policies and procedures that cover the provider inquiries and provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor to file a provider complaint and which individual(s) has the authority to review a provider complaint;	Provider Handbook P/P for provider inquiries P/P for provider complaint system		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 32 to 34.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
9.4.1.5	Information about the Contractor's member grievance and appeal system, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers (including the Provider Compliance Hotline) and the member's right to request continuation of services while utilizing the grievance system in accordance with 42 CFR §438.414;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 4, 39, and 48.	
9.4.1.6	Service authorization criteria to make medical necessity determinations as defined by LDH;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 20 and 51.	
9.4.1.7	Clinical practice guidelines;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 27.	
9.4.1.8	Provider rights and responsibilities;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 10.	
9.4.1.9	PA and referral procedure;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 10 and 11, and the PAHP's website.	
9.4.1.10	Treatment record and documentation requirements;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 37 to 38.	
9.4.1.11	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim submissions and samples of clean and complete claims (troubleshooting tips, common reasons for claim denials, and other helpful information for submitting claims);	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook and the PAHP's website.	
9.4.1.12	Contractor prompt pay requirements (see Section 8);	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 52.	
9.4.1.13	Notice that provider complaints regarding claims	Provider Handbook		Full	This requirement is addressed in the LA CSoC	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	payment shall be sent to the Contractor;				Provider Handbook, page 53.	
9.4.1.14	Quality performance requirements;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 30 and 31.	
9.4.1.15	Appointment access and availability requirements;	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 18.	
9.4.1.16	Information on reporting suspicion of provider or member fraud, waste or abuse; and	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, pages 44 to 47.	
9.4.1.17	Information on obtaining Medicaid transportation services for members.	Provider Handbook		Full	This requirement is addressed in the LA CSoC Provider Handbook, page 18.	
9.4.2	The Contractor shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Example bulletins if applicable		Full	This requirement is addressed in the Final Mail Alert – LA Provider Handbook Update.	
9.5	**Provider Education and Training**					
9.5.1	The Contractor shall have a sufficient number of qualified staff and allocate sufficient financial resources to provide training to all providers.	P/P for provider training		Full	This requirement is addressed in the Annual Provider Training Plan Final 9.5.1 and 9.5.2.	
9.5.2	The Contractor shall provide training to all providers and their staff regarding the requirements of the contract. The Contractor shall conduct initial training within thirty (30) days after finalizing enrollment of a newly contracted provider, or provider group. The Contractor shall also conduct ongoing training, as deemed necessary by the Contractor or LDH, in order to ensure compliance with program standards and the contract. All training will be documented with agendas, written training materials, invited attendees, and sign-in sheets (including documentation of absent attendees). Training to be provided will include but not be limited to:	P/P for provider training Example training materials Sign-in sheets		Full	This requirement is addressed in the Annual Provider Training Plan Final 9.5.1 and 9.5.2 Provider Training Verification Process Final and https://www.magellanoflouisiana.com/for-providers/training-events/provider-training-requirements/.	
9.5.2.1	System of Care values and the provider's role in	P/P for provider training		Full	This requirement is addressed in	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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 Coordinated System of Care;	Example training materials			https://www.magellanoflouisiana.com/media/3193/provider-introduction-to-coordinated-system-of-care-final.pdf.	
9.5.2.2	Cultural Competency;	P/P for provider training Example training materials		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/training-events/cultural-competency/.	
9.5.2.3	Currently implemented Evidence-Based Practices;	P/P for provider training		Full	This requirement is addressed in https://www.magellanoflouisiana.com/media/1902/evidence-based-practices1-13-16.pdf.	
9.5.2.4	Billing and documentation requirements;	Example training materials		Full	This requirement is addressed in https://www.magellanoflouisimag.com/media/4041/new-provider-orientation-final.pdf and https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-resources/claims-processing/.	
9.5.2.5	Utilizing the CANS assessment and IBHA;	P/P for provider training		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/provider-resources/cans-tools/ and https://www.magellanoflouisiana.com/for-providers/training-events/certification-courses/.	
9.5.2.6	Use of Contractor systems and website;	Example training materials		Full	This requirement is addressed in https://magellanprovider.com/education/online-training.aspx.	
9.5.2.7	Home and community-based setting requirements;	P/P for provider training		Full	This requirement is addressed in the LA CSoC Provider Handbook LDH Approved, pages 13	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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 14.	
9.5.2.8	Adverse incidents and reporting requirements;	Example training materials		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/adverse-incident-reporting/.	
9.5.2.9	Program Integrity requirements and reporting; and	P/P for provider training		Full	This requirement is addressed in the LA CSoC Provider Handbook LDH Approved, pages 44 to 47, and https://www.magellanoflouisiana.com/media/2511/fraud-waste-and-abuse-presentation-obh-edit-12-14-15.pdf and https://www.magellanoflouisiana.com/media/4041/new-provider-orientation-final.pdf .	
9.5.2.10	Additional topics as determined through provider/member surveys and/or as directed by LDH.	Example training materials		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/training-events/webinars/ .	
9.5.3 9.5.3.1 9.5.3.2 9.5.3.3	The Contractor is required to demonstrate deep knowledge of system of care values and Wraparound Process in order to provide technical assistance and ensure training for CSoC providers inclusive of the WAAs, FSO and other contracted providers is completed. .1 Required training for the WAAs will include OBH approved Introduction to Wraparound Training and OBH approved Wraparound Coaching Training. .2 Required training for the FSO will include an OBH approved peer training program. .3 Required training for other providers will include an OBH approved child and family team member training.	P/P for provider training Example training materials		Full	This requirement is addressed in https://www.magellanoflouisiana.com/become-a-member/what-is-csoc/introduction-to-wraparound/ and Annual Provider Training Plan Final 9.5.3 and Provider Training Verification Process Final 9.5.3.	
9.5.4	The Contractor shall ensure that providers are trained on the Contractor's administrative	P/P for provider training Example training materials		Full	This requirement is addressed in https://www.magellanoflouisiana.com/medi	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	procedures including credentialing, contracting, authorization requests and use of required Contractor systems for submission of claims and the suite of tools available to providers on the Contractor provider website including the provider handbook.				a/4041/new-provider-orientation-final.pdf and LA CSoC Provider Handbook LDH Approved, pages 9 to 11, 18, 20, and 50 to 52.	
9.5.5	Within thirty (30) days of DOA/OSP approval of the signed contract, the Contractor shall develop, implement, and provide LDH with a copy of an annual training plan that addresses all training requirements, including involvement of members and family members in the development and delivery of trainings.	Annual Training Plan Evidence of timely communication		Full	This requirement was addressed by LDH during on-site visit.	
9.5.6	The Contractor shall submit a copy of any initial provider training materials and a training schedule to LDH for approval within thirty (30) calendar days after the date the signed contract is approved by DOA/OSP. Any changes to the materials or schedule shall be submitted to LDH for approval prior to the scheduled change and dissemination of such change.	initial provider training materials raining schedule Evidence of timely communication		Full	This requirement was addressed by LDH during on-site visit.	
9.5.7	The Contractor shall provide thirty (30) days advance notice of all trainings to LDH, and LDH shall be permitted to attend any and all provider training sessions. The Contractor shall maintain and provide upon LDH request all provider training reports identifying training topics provided, dates, sign-in sheets, invited/attendees lists, and organizations trained.	P/P for notice of training Evidence of timely communication with LDh		Full	This requirement was addressed by LDH during on-site visit.	
9.5.8	The Contractor shall submit all provider informational and training materials and presentations to LDH for written approval prior to distribution.			Full	This requirement was addressed by LDH during on-site visit.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
9.6	**Provider Complaint System**					
9.6.1	A provider complaint is any verbal or written expression, originating from a provider and delivered to any employee of the Contractor, voicing dissatisfaction with a policy, procedure, payment or any other communication or action by the Contractor. Note that member grievance and appeals filed by providers on behalf of a member should be documented and processed with member grievance and appeals policies as outlined in Section 11.	P/P for Provider Complaint System		Full	This requirement is addressed in the Comment Process Policy and Standards and Section 11.	
9.6.2	The Contractor shall establish a Provider Complaint System for providers to dispute the Contractor's policies, procedures, or any aspect of the Contractor's administrative functions. As part of the Provider Complaint System, the Contractor shall:	P/P for Provider Complaint System		Full	This requirement is addressed in the Comment Process Policy.	
9.6.2.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	P/P for Provider Complaint System Staffing report		Full	This requirement is addressed in the Comment Process Policy and Provider Relations Job Description.	
9.6.2.2	Identify a staff person specifically designated to receive and process provider complaints;	P/P for Provider Complaint System		Full	This requirement is addressed in 9.6 Comment Process Policy, page 1.	
9.6.2.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and network provider agreement provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and	P/P for Provider Complaint System P/P for investigation of provider complaints		Full	This requirement is addressed in the provider handbook, pages 32 to 33.	
9.6.2.4	Ensure that Contractor executives with the authority to require corrective action are involved in the provider complaint escalation process as necessary.	P/P for Provider Complaint System		Full	This requirement is addressed in the provider handbook, page 33.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
9.6.3	The Contractor shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The Contractor shall submit its Provider Complaint System policies and procedures to LDH for review and approval within thirty (30) calendar days of the date the Contract with LDH is signed. The policies and procedures shall include, at a minimum:	P/P for Provider Complaint System		Full	This requirement is addressed in the Medicaid Adverse Claims Determinations Policy and provider handbook, pages 33 to 34.	
9.6.3.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaints with the Contractor and the resolution time;	P/P for Provider Complaint System		Full	This requirement is addressed in the provider handbook, page 32.	
9.6.3.2	A description of how and under what circumstances providers are advised that they may file a complaint with the Contractor for issues that are Contractor Provider Complaints and under what circumstances a provider may file a complaint directly to LDH for those decisions that are not a unique function of the Contractor or when the provider has exhausted the Contractor's Provider Complaint System;	P/P for Provider Complaint System		Minimal	This requirement is addressed in the provider handbook, page 32, and Comment Process Policy and Procedure. Missing from the documentation is a description of how and under what circumstances providers may file a complaint with the contractor and under what circumstances a provider may file a complaint directly to LDH. **Recommendation:** The PAHP should include in policy a description of the circumstances under which a provider may file a complaint with the contractor and the circumstances under which a provider may file a complaint directly to LDH.	The provider handbook is currently under annual review. This recommendation will be incorporated into the version pending submission to the LDH on 9/9/19.
9.6.3.3	A description of how Provider Relations staff are trained to distinguish between a provider complaint and a member grievance or appeal in which the provider is acting on the member's behalf;	P/P for Provider Complaint System Training materials		Full	This requirement is addressed in the Grievance Training Materials CART, pages 1 to 2.	
9.6.3.4	A process to allow providers to consolidate	P/P for Provider Complaint		Full	This requirement is addressed in the	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	System			provider handbook, page 34.	
9.6.3.5	A process for thoroughly investigating each complaint and for collecting pertinent facts from all parties during the investigation and ensuring that provider complaints are acknowledged within three (3) business days of receipt; resolve and/or state the result communicated to the provider within thirty (30) business days of receipt (this includes referrals from LDH). If not resolved in thirty (30) business days, the Contractor must document why the issue goes unresolved; however, the issue must be resolved within ninety (90) calendar days;	P/P for Provider Complaint System P/P for investigation of provider complaints Includes File Review		Full	This requirement is addressed in the provider handbook, page 34, and in the Grievance Complaint Workflow. **File Review Results:** Three (3) of 3 grievance files reviewed were compliant.	
9.6.3.6	A description of the methods used to ensure that Contractor executive staff with the authority to require corrective action is involved in the complaint process, as necessary;	P/P for Provider Complaint System		Full	This requirement is addressed in the LA Magellan Medicaid Addendum CSoC Readiness Review, page 5.	
9.6.3.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	P/P for Provider Complaint System		Full	This requirement is addressed in the provider handbook, page 32.	
9.6.3.8	Identification of specific individuals who have authority to administer the provider complaint process;	P/P for Provider Complaint System		Full	This requirement is addressed in the Magellan CSoC QAPI Program Description_11.01.2019-12.31.2019_5.29.19, pages 32 to 33.	
9.6.3.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider	P/P for Provider Complaint System System reports generated		Full	This requirement is addressed in the Comment Process Policy, page 4.	

Provider Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	complaints, whether received by telephone, in person, or in writing; and	during review period				
9.6.3.10	A provision requiring the Contractor to report the status of all provider complaints and their resolution to at a frequency to be determined by LDH and in the format required by LDH.	P/P for Provider Complaint System System reports generated during review period		Full	This requirement is addressed in Comment Process Policy on page 2.	
9.6.4	The Contractor shall distribute the Contractor's Provider Complaint System policies and procedures to network providers at time the network provider agreement is complete. The Contractor may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the Contractor's website. This summary shall also detail how the provider can request a hard copy from the Contractor at no charge to the provider.	Evidence of distribution		Full	This requirement is addressed in the provider handbook and postcard update.	
9.6.5	The Contractor shall maintain all of the above information and forms on its provider website to allow submittal of complaints electronically. In addition, the Contractor shall provide providers with an address to submit complaints in writing and a phone number to submit complaints by telephone.	P/P for Provider Complaint System P/P for website		Full	This requirement is addressed in https://www.magellanoflouisiana.com/for-providers/provider-toolkit/grievances-and-appeals/.	

Enrollment

Enrollment						
Contract Reference	State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)	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
10	**ENROLLMENT**					
10.1	**Enrollment of Children and Youth for CSoC**					
10.1.1	Upon enrollment in CSoC including a clinical presumptive determination of need, eligible children and youth are assigned to the Contractor for management of specialized behavioral health and waiver services.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Eligibility Workflow, Eligibility Procedure, and Receiving Referral Call from HLP Procedure.	
10.1.1.1	Screening, clinical eligibility assessment and CSoC enrollment may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Receiving a CSoC Referral Call from HLP Procedure.	
10.1.1.2	The Contractor will screen and conduct the brief CANS, if appropriate, on non-Medicaid youth to determine clinical eligibility. For youth in which the brief CANS indicates clinical eligibility, the Contractor shall initiate a referral for Medicaid eligibility determination in accordance with standard operation procedures. For youth in which the brief CANS does not indicate clinical eligibility, the Contractor shall provide contact information to the youth/family to apply for Medicaid and potential receipt of other non-CSoC services, if requested.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Receiving Referral Call from HLP Procedure.	
10.1.1.3	Screening, clinical eligibility assessment and CSoC enrollment may also take place while a youth resides in an out-of-home LOC (such as PRTF or TGH) and is preparing for discharge to a $_{home}$ and community-based setting. Screening, clinical eligibility assessment, and CSoC enrollment should be conducted 30 days (not to exceed ninety (90) days) prior to discharge from a residential setting, as it is expected to assist in comprehensive	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Non-HCBS Setting Procedure and Special Considerations for Youth in PRTF at Time of Referral Procedure.	

Enrollment						
Contract Reference	State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)	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
	discharge and treatment planning, prevent disruption, and improve stabilization upon reentry to a home and community environment.					
10.1.1.4	A child enrolled in CSoC who enters a residential treatment setting may remain in CSoC if they have an approved Plan of Care (POC), agreed upon by an active and functional Child and Family Team (CFT), that 1) indicates that after exhausting all other community resources, the CFT is in agreement that the child will enter into the residential setting for up to thirty (30) days, not to exceed ninety (90) days, 2) treatment in the residential setting will target increasing stabilization in order for the child to return to his/her home and community for continued work with the CFT, 3) the POC identifies a working plan to expedite return to the community, inclusive of defining resources that need to be pursued, and 4) the POC indicates that while the youth stays in the residential setting, the CFT will meet weekly (by conference call, if needed) to further develop, review and update the POC. The Contractor will ensure that Wraparound Facilitators make all efforts such that the child and family, the residential facility staff who work directly with the child and family, and any current or newly identified community providers be in attendance at these CFTs. These criteria may be further delineated in the Standard Operating Procedures.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the PRTF Request for Current CSoC Youth Procedure and by on-site discussions with Magellan.	
10.1.1.5	The Contractor may only permit eligible individuals, who reside in an institution (such as an inpatient hospital, nursing facility, IMD, ICF/DD, or PRTF) or other non-HCBS setting (such as a group home, any setting on the grounds of or adjacent to a public institution, or any setting	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Non-HCBS Setting Procedure.	

Enrollment						
Contract Reference	State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)	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
	located in a building that also provides inpatient institutional treatment), to receive Wraparound Services under the 1915(b)(3) authority for up to ninety (90) days while the participant remains in the institutional/non-HCBS setting for discharge planning purposes to ensure a successful transition to a home and community-based setting and, when clinical eligibility is met, enrollment in the 1915 (c) waiver.					
10.1.2	The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member's choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Retrieving Referral Procedure, page 3.	
10.1.3	The Contractor shall not discriminate against Contractor members on the basis of their health history, health status, need for healthcare services or adverse change in health status; or on the basis of age, race, color, national origin, disability, religious belief, sex, sexual orientation, or gender identity, in compliance with 42 CFR §438.3(d).	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Magellan Nondiscrimination Notice. Questions about how the notice is distributed were answered on-site.	
10.1.4	The Contractor shall not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability, in	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Magellan Nondiscrimination Notice.	

Enrollment						
Contract Reference	State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)	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
	compliance with 42 CFR §438.3(d).					
10.1.5	The Contractor shall not request disenrollment of any member who is eligible for CSoC services because of the member's adverse change in health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs and shall comply with applicable disenrollment sections of 42 CFR §438.56.	P/P for Eligibility and Enrollment Standard Operating Procedures		Full	This requirement is addressed in the Magellan Nondiscrimination Notice.	
10.1.6	The Contractor may not disenroll CSoC members for any reason other than discharge from CSoC. Eligible recipients may choose to no longer participate in CSoC in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge. The state will disenroll effective the 1st day of a month members who lose Medicaid eligibility.	P/P for Eligibility and Enrollment Standard Operating Procedures		Substantial	This requirement is addressed in the Discharge from CSoC Procedure Workflow. Missing is the requirement that the contractor may not disenroll CSoC members for any reason other than discharge from CSoC. **<u>Recommendations:</u>** The PAHP should include in the policy the requirement that the contractor may not disenroll CSoC members for any reason other than discharge from CSoC. During on-site discussions, the PAHP indicated that the missing language will be added to future policy.	Magellan's procedure will be updated to include IPRO's recommendation. The revision will be sent to the LDH for approval by 8/31/19.

Grievance and Appeal System

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.1	**Adverse Benefit Determinations, Grievance and Appeal Procedures**					
11.1.1	The Contractor shall conduct adverse benefit determinations as provided for in this contract and in accordance with state and federal law and regulation. Upon making such determination, the Contractor shall provide all notices required herein as well as all opportunities for grievance and appeals required by this Section or by state or federal law or regulations. The grievance system must comply with 42 CFR §438 Subpart F. The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws and Medicaid State Plan, 1915(b), and 1915(c) waiver.	P/P for Adverse Benefit Determination		Full	This requirement is addressed in the Medicaid Adverse Benefit Determination Appeal Policy and Standards, page 2.	
11.1.2	The Contractor must have a grievance system in place for members that includes a grievance process, an appeal process, and access to the State Fair Hearing system, once the Contractor's appeal process has been exhausted. The Contractor may have one level of appeal for members in accordance with 42 CFR §438.402(b).					
11.1.3	The Contractor's grievance and appeals procedure and any changes thereto must be approved in writing by LDH prior to their implementation and shall include, at a minimum, the requirements set forth in this contract.					
11.1.4	The Contractor shall refer all Contractor members who are dissatisfied with the Contractor or its subcontractors, or its network providers in any	P/P for Grievances and Appeals		Full	This requirement is addressed in the Comment Process Policy and Standards, page 3.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	respect to the Contractor's staff authorized to review and respond to appeals and require corrective action					
11.1.5	The member or provider must exhaust the Contractor's internal grievance/appeal procedures as described in the Member Handbook prior to accessing the Louisiana State Fair Hearing process, hereafter referred to as, State Fair Hearing.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 3, and the member handbook, pages 14 to 19.	
11.1.6	When the term "member" is used throughout Section 11 it includes the member, member's authorized representative, or provider with the member's prior written consent.					
11.1.7 11.1.7.1 11.1.7.2 11.1.7.3 11.1.7.4 11.1.7.5 11.1.7.6	The Contractor shall not create barriers to timely due process. The Contractor may be subject to remediation, as determined in Section 18, if it is determined by LDH that the Contractor has created barriers to timely due process, and/or, if ten percent (10%) or higher of appeal decisions appealed to a State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of impermissible barriers include but are not limited to: 1. Labeling grievances as inquiries or complaints and funneled into an informal review. 2. Failing to inform members of their due process rights. 3. Failing to log and process grievances and appeals. 4. Failure to issue a proper notice, including vague or illegible notices. 5. Failure to inform of continuation of benefits; and 6. Failure to inform of right to State Fair Hearing	P/P for Grievances and Appeals Communication with LDH if applicable		Full	This requirement is addressed in the CSoC Provider Monitoring Program Description, pages 29 to 30.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	following the Contractor's internal appeal process.					
11.1.8	The Contractor website must allow members to initiate a grievance or appeal through the availability of optional forms to be submitted via the website or via an automated email submission built into the form. However, in addition, a grievance or appeal may be requested orally and in writing.	P/P for Grievances and Appeals P/P for website Review of website		Full	This requirement is addressed in the CSoC Member Handbook, page 14, and website screen shots.	
11.1.9	The Contractor's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and how to instruct a member to file a grievance/appeal.	P/P for Grievances and Appeals Training materials Sign-in sheets		Full	This requirement is addressed in the Comment and Resolution Tracking (CART) for Member Grievances and Provider Complaints training.	
11.1.10	Notices of Action to members shall be in compliance with any agreements that LDH may enter into relative to the timing of notice, format of notice, or contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out of court settlements.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 1.	
11.3	**Notice of Adverse Benefit Determination**					
11.3.1 11.3.1.1	Language and Format Requirements .1 The Notice of Adverse Benefit Determination must be in writing and must meet the language and format requirements of 42 CFR §438.10 and Section 5 of this contract to ensure ease of understanding.	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standard, page 5.	
11.3.2 11.3.2.1 11.3.2.2 11.3.2.3 11.3.2.4	Content of Notice of Adverse Benefit Determination must explain the following: 9. The adverse benefit determination the Contractor intends to take; 10. The reasons for the adverse benefit	P/P for Notice of Adverse Benefit Determination Includes File Review		Substantial	This requirement is addressed in the CSoC Inpt Clinical Denial_Full Final, page 2. **File Review Results:** Nine (9) out of 10 appeal files reviewed	Magellan's non-compliant record resulted from processor error. The following will occur, by 9/30/19: A refresher

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.3.2.5 11.3.2.6 11.3.2.7 11.3.2.8	determination; 11. The member's right to request an appeal of the Contractor's adverse benefit determination; 12. The member's right to request a State Fair Hearing, after the Contractor's one level of appeal has been exhausted; 13. The procedures of exercising the rights specified in this Section; 14. The circumstances under which the expedited appeal process is available and how to request it; 15. 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 16. Availability of interpretation services for all languages and how to access them.				were compliant. One (1) member did not receive a notice of adverse benefit determination. **Recommendation:** The PAHP should ensure all members who have had benefits denied receive a notice of adverse benefit determination.	training on adverse benefit determinations will be conducted. An Appeals and Grievances training module will be developed and completed by all impacted staff (and new hires, moving forward). Magellan will continue to monitor denial and appeal files to ensure accuracy and timeliness.
11.3.3	Timing of Notice of Adverse Benefit Determination					
11.3.3.1	The Contractor must mail the Notice of Adverse Benefit Determination within the following timeframes:					
11.3.3.1.1	For termination, suspension or reduction of previously authorized Medicaid-covered services, at least ten (10) calendar days before the date of action;	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2.	
11.3.3.1.2	In cases of verified member fraud, at least five (5) calendar days before the date of action; or	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2.	
11.3.3.1.3	By the date of action for the following:	P/P for Notice of Adverse		Full	This requirement is addressed in the Notice	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.3.3.1.3.1 11.3.3.1.3.2 11.3.3.1.3.3 11.3.3.1.3.4 11.3.3.1.3.5 11.3.3.1.3.6 11.3.3.1.3.7	1. In the death of a member; 2. A signed written member statement requesting service termination or giving information requiring termination or reduction of services (where the member understands that this must be the result of supplying that information); 3. The member's admission to an institution where the member is ineligible for further services; 4. The member's address is unknown and mail directed to the member has no forwarding address; 5. The member has been accepted for Medicaid services by another State or jurisdiction; 6. The member's physician prescribes the change in the level of medical care; or 7. As otherwise permitted under 42 CFR §431.213.	Benefit Determination			of Adverse Benefit Determination Procedure, page 2.	
11.3.3.1.4	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 network provider and the Contractor.	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2.	
11.3.3.1.5 11.3.3.1.5.1 11.3.3.1.5.2 11.3.3.1.5.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional days, only if: 1. The member requests extension; or 2. For good cause shown and upon express assumption of any liability resulting from such delay; or 3. The Contractor justifies (to LDH upon request) a need for additional information and how	P/P for Notice of Adverse Benefit Determination Includes File Review		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2. **File Review Results:** No extensions were requested in reviewed files.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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 extension is in the member's interest.					
11.3.3.1.6 11.3.3.1.6.1 11.3.3.1.6.2 11.3.3.1.6.3	If the Contractor extends the timeframe in accordance with Section 11.3.3.1.5 above, it must: 1. Make reasonable efforts to give the member prompt oral notice of the delay; and 2. 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; and 3. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Notice of Adverse Benefit Determination Includes File Review		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2. **File Review Results:** In 10 out of 10 files, an extension was not requested.	
11.3.3.1.7	Untimely authorizations constitute a denial and are thus adverse benefit determinations on the date the timeframe for service authorization expires as specified in Section 11.2.1. 5.	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2.	
11.3.3.1.8	For expedited service authorization decisions where a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or the ability to attain, maintain, or regain maximum function, the Contractor 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 Adverse Benefit Determination Includes File Review - Expedited		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2. **File Review Results:** In 10 out of 10 files, an extension was not requested.	
11.3.3.1.9	The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member requests an extension, or if the Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Adverse Benefit Determination		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.3.4 11.3.4.1 11.3.4.2	Authority to File. .1 A member, or authorized representative acting on the member's behalf, may file a grievance and Contractor level appeal, and may request a State Fair Hearing, once the Contractor's appeals process has been exhausted. .2 A network provider, acting on behalf of the member and with the member's prior written consent, may file an appeal. The provider may also file a Contractor level appeal and may request a State Fair Hearing on behalf of a Member with written consent, once the Contractor's appeals process has been exhausted.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Notice of Adverse Benefit Determination Procedure, page 2, and the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 4.	
11.3.5 11.3.5.1 11.3.5.2 11.3.5.3	Time Limits for Filing .1 The Contactor shall permit a member to file a grievance and request a Contractor 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 adverse benefit determination is upheld or once the Contractor's appeals process has been exhausted. .2 The member shall be permitted to file a grievance at any time. **.3** The member shall be allowed sixty (60) calendar days from the date on the Contractor's notice of adverse benefit determination to request an appeal.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid Enrollee Grievances Policy and Standards, page 4, the Medicaid: Adverse Benefit Determination Appeal, page 7, and CSoC Inpt Clinical Denial_Full Final letter.	
11.3.6 11.3.6.1 11.3.6.2 11.3.6.3	Procedures for Filing .1 The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid Adverse Benefit Determination Appeal Policy and Standards, pages 2 to 3, and CSoC Member Appeal Form, and	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.3.6.4	written consent, may file a grievance either orally or in writing, including online through the Contractor's website, with the Contractor. The Contractor shall confirm an oral appeal in writing. .2 The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may request an appeal either orally or in writing, including online, and unless he or she requests expedited resolution, must follow the oral filing with a written, signed appeal request. .3 The Contractor shall ensure that all Contractor members and providers are informed of the Contractor's grievance and appeal procedures and of the State Fair Hearing process. The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures. Forms on which members may file grievances and appeals to the Contractor shall be available through the Contractor, and paper copies shall be provided by the Contractor upon request of the member. The Contractor shall make all forms easily available on the Contractor's website. .4 If an employee of the Contractor has reason to believe that a member has cause or a desire to file a grievance or appeal but is unaware of the right to do so, the employee shall have an affirmative duty to inform the member of his right to file such grievance or appeal and the procedure for doing so.				Medicaid Enrollee Grievances Policy, page 4, and Medicaid Adverse Benefit Determination Appeal Policy, pages 2 to 3, and member handbook, page 14, and Magellan CSoC Provider Monitoring Program Description, page 29.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.4	**Handling of Grievances and Appeals**					
11.4.1 11.4.1.1	General Requirements In handling grievances and appeals, the Contractor must meet the following requirements:					
11.4.1.1.1	Acknowledge receipt of each grievance and appeal in writing within three (3) 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 grievance log.	P/P for Grievances and Appeals Evidence of timely communication Includes File Review		Full	This requirement is addressed in the Grievance and Complaint Procedure, page 2, and in the file review. **File Review Results:** Six (6) out of six (6) grievance and appeal files reviewed were compliant.	
11.4.1.1.2	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/TDD and interpreter capability;	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid: Entrollee Grievances Policy and Standards, page 2.	
11.4.1.1.3. 11.4.1.1.3.1	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;	P/P for Grievances and Appeals Includes File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, pages 3 to 4. **File Review Results:** Thirteen (13) of 13 grievance and appeals files reviewed were compliant.	
11.4.1.1.3.2 11.4.1.1.3.2.1 11.4.1.1.3.2.2 11.4.1.1.3.2.3	Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: 1. An appeal of a denial that is based on lack of medical necessity. 2. A grievance regarding denial of expedited resolution of an appeal based on a member's condition or disease.	P/P for Grievances and Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, page 4. **File Review Results:** Thirteen (13) of 13 grievance and appeals files reviewed were compliant.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	3. A grievance or appeal that involves clinical issues.					
11.4.1.1.3.3	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 adverse benefit determination.	P/P for Grievances and Appeals		Full	This requirement is addressed in the CSoc Member Handbook, page 17, and the Medicaid Enrollee Grievances Policy and Standards, page 3.	
11.4.1.2	Special requirements for grievances involving quality of care (QOC) concerns					
11.4.1.2.1 11.4.1.2.1.1 11.4.1.2.1.2 11.4.1.2.1.3 11.4.1.2.1.4	The Contractor shall address quality of care concerns through the grievance process. This includes investigating, analyzing, tracking, trending, disposing, and reporting, including adherence to all relevant LDH critical incident reporting requirements and the following: 1. Conducting follow-up with the member, family/caregiver and custodial state agency, if applicable, to determine whether the immediate behavioral healthcare needs are met, including follow up after discharge from inpatient levels of care within seventy-two (72) hours. 2. Referring grievances with quality of care issues to the Contractor's peer review committee, when appropriate. 3. Referring or reporting the grievance quality of care issue(s) to the appropriate regulatory agency, child or adult protective services and LDH for further research, review, or action, when appropriate. 4. Notifying LDH and the appropriate regulatory or licensing board or agency when the provider agreement with a network provider	P/P for Grievances and Appeals		Full	This requirement is addressed in the Quality of Care Concerns Procedure, page 4, file review, and on-site discussion with the PAHP.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	is suspended or terminated due to quality of care concerns.					
11.4.2	Special Requirements for Appeals					
11.4.2.1	The process for appeals must provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible request date for the appeal). The member may request an expedited appeal either orally or in writing.	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, pages 3 to 4.	
11.4.2.2	The process for appeals must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member in advance of timeframes for appeals. The Contractor must inform the member of the limited time available in the cases of an expedited appeal.	P/P for Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, page 4. **File Review Results:** Ten (10) of 10 appeals files reviewed were compliant.	
11.4.2.3	The process for appeals must provide the member an opportunity to examine their case file, including treatment records, other documents and records considered during the appeals process and any new or additional evidence considered, relied upon or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the date by which the Contractor must resolve the appeal.	P/P for Appeals File Review		Substantial	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, page 4. **File Review Results:** Nine (9) of 10 appeals files reviewed were compliant. One (1) of 10 appeals file reviewed was not compliant. **Recommendation:** The PAHP should ensure that all members who file an appeal and whose appeal is denied receive a notice of adverse benefit determination.	Magellan's non-compliant record resulted from processor error. The following will occur, by 9/30/19: A refresher training on adverse benefit determinations will be conducted. An Appeals and Grievances training module will be developed and completed by all impacted staff (and new hires, moving forward). Magellan will continue to monitor denial and appeal files to ensure accuracy and timeliness.

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.4.2.4 11.4.2.4.1 11.4.2.4.2	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 <u>File Review</u>		Substantial	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, pages 4 to 5. **<u>File Review Results:</u>** Eight (8) of 10 appeals files were compliant. Two (2) of 10 appeals files reviewed were not compliant. **<u>Recommendation:</u>** For cases where a denial is overturned after an appeal, the PAHP should create a draft letter that includes the member's representative.	Magellan will revise the Notice of Action template to include a member's representative by 8/31/19. The staff will receive a training alert with the updated information, and we will implement ongoing audits to ensure that the correct template is being utilized.
11.4.3 11.4.3.1	Training of Contractor Staff The Contractor staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the members and providers. The Contractor shall ensure staff are educated regarding applicable grievance definitions.	P/P for Appeals Training Materials Sign-in sheets		Full	This requirement is addressed in the CSoC Training Agenda and Comment and Resolution Tracking (CART) for Member Grievances and Provider Complaints, page 1.	
11.4.4 11.4.4.1	Identification of Appropriate Party The Contractor grievance and appeal procedures shall identify the appropriate individual or body within the Contractor's staff having decision making authority as part of the grievance and appeal procedures.	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 3.	
11.4.5 11.4.5.1 11.4.5.2	Failure to Make a Timely Decision Appeals shall be resolved no later than the time frames specified in Section 11.4.9. and all parties shall be informed of the Contractor's decision. .1	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and 11.4.9.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.4.6 11.4.6.1	Right to State Fair Hearing The Contractor shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the Contractor's decision in response to an appeal and the process for doing so.	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Enrollee Grievances Policy and Standards.	
11.4.7 11.4.7.1	Resolution and Notification The Contractor must resolve a grievance and/or appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Enrollee Grievances Policy and Standards, page 4, and 11.4.8.	
11.4.8	Specific Timeframes					
11.4.8.1 11.4.8.1.1	Standard Resolution of Grievances .1 For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.	P/P for Grievances File Review		Full	This requirement is addressed in the Medicaid: Enrollee Grievances Policy and Standards, page 7. **File Review Results:** Three (3) of 3 grievance files reviewed were compliant.	
11.4.8.2 11.4.8.2.1	Standard Resolution of Appeals .1 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 Contractor receives the appeal. This timeframe may be extended under Section 11.4.8.4.	P/P for Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10. **File Review Results:** Three (3) out of 3 standard resolution appeals files reviewed were compliant.	
11.4.8.3 11.4.8.3.1	Expedited Resolution of Appeals .1 For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the Contractor receives the appeal. This timeframe may be extended under Section 11.4.8.4.	P/P for Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 9. **File Review Results:** Seven (7) of 7 expedited appeals reviewed were compliant.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.4.8.4	Extension of Timeframes					
11.4.8.4.1 11.4.8.4.1.1	The Contractor may extend the timeframes of this section by up to fourteen (14) calendar days if: The member requests the extension; or	P/P for Grievances and Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10. **File Review Results:** In 10 out of 10 files, an extension was not requested.	
11.4.8.4.1.2	The Contractor shows (to the satisfaction of LDH, upon its request) that there is need for additional information and how the delay is in the member's interest.			Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10.	
11.4.8.4.2 11.4.8.4.2.1 11.4.8.4.2.1.1	Requirements Following Timeframe Extension If the Contractor extends the timeframes, it must, for any extension not requested by the member: Make reasonable efforts to give the member prompt oral notice of the delay; and	P/P for Grievances and Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10. **File Review Results:** In 10 out of 10 files, an extension was not requested.	
11.4.8.4.2.1.2	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; and	P/P for Grievances and Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10. **File Review Results:** In 10 out of 10 files, an extension was not requested.	
11.4.8.4.2.1.3	Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Grievances and Appeals File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 10. **File Review Results:** In 10 out of 10 files, an extension was not requested.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.4.8.4.3 11.4.8.4.3.1	Deemed Exhaustion of Appeals .1 In the case of the Contractor that fails to adhere to the notice and timing requirements in this section, the member is deemed to have exhausted the Contractor's appeal process and may initiate a State Fair Hearing.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 3.	
11.4.9	Process for Expedited Resolution					
11.4.9.1 11.4.9.1.1 11.4.9.1.1.1 11.4.9.1.1.2	The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. If the Contractor denies a request for expedited resolution of an appeal, it must: 1. Transfer the appeal to the timeframe for standard resolution in accordance with Section 11.4.9.2. 2. Make reasonable efforts to give the member prompt oral notice of the denial of request for expedited resolution, and follow up within two (2) calendar days with a written notice.	P/P for Grievances and Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, pages 8 to 9.	
11.4.9.2	The denial of a request for expedited resolution of appeal does not constitute an adverse benefit determination or require a Notice of Adverse Benefit Determination. The member may file a grievance in response the denial of a request for expedited resolution of an appeal.					
11.4.9.3	Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the Contractor's resolution in writing. If resolution is not made by the above timeframes,	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, pages 3 and 9.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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's request will be deemed to have exhausted the Contractor's process as per Section 11.4.8.4.3. above.					
11.4.10 11.4.10.1	Authority to File Expedited Appeal 1. The member, the member's representative, or their provider acting on behalf of the member and with the member's prior written consent, may file an expedited appeal either orally or in writing.	P/P for Appeals		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, pages 2 to 3.	
11.4.11 11.4.11.1	Format of Notice of Resolution All notices must meet the standards described in 42 CFR §438.10.	P/P for Notice of Resolution		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, pages 5 to 6.	
11.4.12	Content of Notice of Grievance Resolution					
11.4.12.1 11.4.12.1.1	The Contractor will provide written notice to the member of the resolution of a grievance via a letter to the originator of the grievance containing, at a minimum: 1. Sufficient detail to foster an understanding of the quality of care resolution, if grievance was a quality of care issue;	P/P for Notice of Resolution <u>File Review</u>		Full	This requirement is addressed in the Member Resolution Letter_Revised 5.22.2019. **<u>File Review Results:</u>** Three (3) of 3 grievance files reviewed were compliant.	
11.4.12.1.2	2. A description of how the member's behavioral healthcare needs will or have been met; and	P/P for Notice of Resolution <u>File Review</u>		Full	This requirement is addressed in the Member Resolution Letter_Revised 5.22.2019. **<u>File Review Results:</u>** Three (3) of 3 grievance files reviewed were compliant.	
11.4.12.1.3	3. A contact name and telephone number to call for assistance or to express any unresolved concern	P/P for Notice of Resolution <u>File Review</u>		Full	This requirement is addressed in the Member Resolution Letter_Revised 5.22.2019. **<u>File Review Results:</u>**	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
					Three (3) of 3 grievance files reviewed were compliant.	
11.4.13	Content of Notice of Appeal Resolutions					
11.4.13.1	For all appeals, the Contractor must provide written notice to the member of the resolution.	P/P for Notice of Resolution File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and CSoc Appeal Full Clinical Denial_Final. **File Review Results:** Ten (10) of 10 appeals files reviewed were compliant.	
11.4.13.2	For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice to the member and shall provide the notice in writing.	P/P for Notice of Resolution		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6. **File Review Results:** Seven (7) of 7 files reviewed were compliant. **Final Review Determination:** The review determination is changed to Full based on Magellan's response and additional explanation. Seven (7) of 7 appeals files reviewed were compliant.	We respectfully disagree with IPRO's determination. The member files identified as non-complaint were expedited appeals requests submitted by inpatient providers while the member was still under the provider's care. Magellan provides oral notification to the provider, or the member's representative, in these cases as the member is residing with and under the care of the provider.
11.4.13.3	The written notice of the resolution must include the results of the resolution process and the date it was completed.	P/P for Notice of Resolution File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and CSoc Appeal Full Clinical Denial_Final. **File Review Results:** Ten (10) of 10 appeals files reviewed were	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
					compliant.	
11.4.13.4	For appeals not resolved wholly in favor of the members, the written notice must include: 1.	P/P for Notice of Resolution File Review		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 7, and CSoc Appeal Full Clinical Denial_Final.	
11.4.13.4.1.	The right to request a State Fair Hearing, and how to do so;			Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and CSoc Appeal Full Clinical Denial_Final. **File Review Results:** Seven (7) of 7 appeals files reviewed were compliant.	
11.4.13.4.2	The right to request to receive benefits while the hearing is pending, and how to make the request; and			Minimal	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6, and CSoc Appeal Full Clinical Denial_Final. **Recommendation:** The PAHP should clearly inform the member in the appeals resolution notice that the member has the right to request to receive benefits while the state fair hearing is pending, and to provide information on how to make this request. **Final Review Determination:** No change in determination. This item is found in CFR 438.408 Resolution and notification: Grievances and appeals, (e) Content of notice of appeal resolution. The written notice of the resolution must include the following: (ii) The right to request and receive benefits	We respectfully disagree with your review determination. Magellan has been utilizing the current Notice of Action template, based on guidance from the LDH. We will discuss IPRO's recommendations during our meeting with them on 8/22/19.

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
					while the hearing is pending, and how to make the request.	
11.4.13.4.3	That the member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action.			Non-compliance	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6. Also addressed in file review. Zero (0) of 7 appeals files reviewed were compliant. Seven (7) of 7 appeals files reviewed were not compliant. **Recommendation:** The PAHP should communicate in writing to the member that they may be held liable for the cost of those benefits if the state fair hearing decision upholds the contractor's action. **Final Review Determination:** No change in determination. This item is found in CFR 438.408 Resolution and notification: Grievances and appeals, (e) Content of notice of appeal resolution. The written notice of the resolution must include the following: (iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PAHP's, or PAHP's adverse benefit determination.	We respectfully disagree with your review determination. Magellan has been utilizing the current Notice of Action template, based on guidance from the LDH. We will discuss IPRO's recommendations during our meeting with them on 8/22/19.
11.4.14	State Fair Hearings					
11.4.14.1	LDH shall comply with the requirements of 42 CFR §431.200(b), §431.220(4) and 42 CFR §438.414					

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and §438.10(g)(1). The Contractor shall comply with and all other requirements as outlined in this contract.					
11.4.14.2	The member may request a State Fair Hearing only after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the Contractor's notice of resolution.	P/P for request of State Fair Hearing		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 11.	
11.4.14.3	The member may initiate a State Fair Hearing following deemed exhaustion of appeals processes.					
11.4.14.4 11.4.14.4.1 11.4.14.4.2 11.4.14.4.3 11.4.14.4.4	At the discretion of LDH, an external medical review may be offered and arranged as described below: .1 The review shall be at the member's option and must not be required before, or used as a deterrent to, proceeding to the State Fair Hearing. .2 The review shall be independent of both the State and the Contractor. .3 The review shall be offered without any cost to the member. .4 The review shall not extend any timeframes specified in 42 CFR §438.408 and must not disrupt continuation of benefits as per 42 CFR §438.420.					
11.4.14.5	The parties to the State Fair Hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.	P/P for request of State Fair Hearing		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 3.	
11.5	**Prohibition Against Punitive Action**					
11.5.1	The Contractor shall not take punitive action	P/P for Appeals		Full	This requirement is addressed in the	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	against a provider acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.				Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 4, and the provider handbook, page 39.	
11.6	**Continuation of Benefits**					
11.6.1 11.6.1.1 11.6.1.2	As used in this section, timely filing means filing on or before the later of the following: 1. Within ten (10) calendar days of the Contractor mailing the notice of action adverse benefit determination; or 2. The intended effective date of the Contractor's proposed adverse benefit determination.					
11.6.2 11.6.2.1 11.6.2.2 11.6.2.3 11.6.2.4 11.6.2.5	The Contractor must continue the member's benefits if: .1 The member files the appeal timely in accordance with 42 CFR §438.420(c)(1)(ii) and (c)(2)(ii); .2 The appeal involves the termination, suspension, or reduction of previously authorized services; .3 The services were ordered by an authorized provider; .4 The period covered by the original authorization has not expired; and .5 The member timely files for continuation of benefits.	P/P for Grievance and Appeals P/P for Continuation of Benefits		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 12.	
11.6.3	Duration of Continued or Reinstated Benefits					
11.6.3.1 11.6.3.1.1 11.6.3.1.2 11.6.3.1.3	If, at the member's request, the Contractor continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: 1. The member withdraws the appeal or request	P/P for Grievance and Appeals P/P for Continuation of Benefits P/P for Reinstated Benefits		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 6.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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 State Fair Hearing. 2. The member fails to request a State Fair Hearing or continuation of benefits within ten (10) calendar days after the Contractor mails the notice of adverse resolution to the member's appeal; 3. A State Fair Hearing Officer issues a hearing decision adverse to the member.					
11.6.3.2	A provider may not request continuation of benefits for the member.	P/P for Continuation of Benefits Provider Handbook		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 3.	
11.6.4 11.6.4.1	Member Responsibility for Services Furnished While the Appeal is Pending 1. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal and State Fair Hearing was 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 CFR §431.230(b).	P/P for Grievance and Appeals P/P for Continuation of Benefits		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 13.	
11.6.5 11.6.5.1 11.6.5.2.	Effectuation of Reversed Appeal Resolutions 1. If the Contractor 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 Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.	P/P for Grievance and Appeals P/P for Continuation of Benefits		Full	This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal Policy and Standards, page 12.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
	2. If the Contractor 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 Contractor must pay for those services, in accordance with this contract.					
11.6.6 11.6.6.1	Information to Subcontractors and Network Providers The Contractor must provide the information specified in 42 CFR §438.414 about the grievance and appeal system to all subcontractors and network providers at the time they enter a contract.	P/P for Grievance and Appeals Provider Handbook		Full	This requirement is addressed in the provider handbook, pages 34 and 38 to 39.	
11.7	**Grievance/Appeal/State Fair Hearing Records and Reports**					
11.7.1	The Contractor must maintain records of all grievances and appeals. A copy of grievances logs and records of resolution of appeals shall be retained for ten (10) years from the date of the grievance or appeal resolution. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Enrollee Grievances Policy and Standards, page 5, and Medicaid: Record Retention, Transport and Destruction Supplement Policy and Standards, page 2.	
11.7.2	The Contractor shall electronically provide LDH with grievance and appeal reports in a format prior approved by LDH in accordance with the requirements outlined in this contract, and at the frequency established by LDH to include, but not be limited to:	P/P for Grievance and Appeals Evidence of provision if applicable		Full	This requirement is addressed in the Member Grievance Report Template and G_A_SFH Records and Reports Procedure.	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
11.7.2.1	General description of the reason for the appeal or grievance;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport and Destruction Supplement, pages 2 to 3, GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.2	Date the request was received;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport, and Destruction Supplement, pages 2 to 3, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.3	Date of each review, and if applicable, date of each review meeting;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport, and Destruction Supplement, pages 2 to 3, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.4	Resolution of each appeal or grievance, if applicable;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport, and Destruction Supplement, pages 2 to 3, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.5	Date of resolution at each level, if applicable;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport, and Destruction Supplement, pages 2 to 3, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.6	Member name and Medicaid number;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Medicaid: Record Retention, Transport, and Destruction Supplement, pages 2 to 3, and	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 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
					GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.7	Summary of grievances and appeals;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.8	Current status;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.9	Resolution with date of resolution and resulting corrective action;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.10	The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM01 Member Grievance Report Template, and GM02_CSoC Member Appeals and SFH Report Template, and GM03_CSoC Provider Grievances and Appeals Report Template.	
11.7.2.11	The status and resolution of all claims disputes;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM03_CSoC Provider Grievances and	

Grievance and Appeal System						
Contract Reference	State Contract Requirements (Federal Regulations 438.228, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Appeals Report Template.	
11.7.2.12	Trends and types of grievances and appeals;	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.2.13	The number of grievances and appeals in which the Contractor did not meet timely disposition or resolution; and	P/P for Grievance and Appeals		Full	This requirement is addressed in the grievance and appeal reporting template used by Magellan and developed by LDH.	
11.7.2.14	The number of State Fair Hearings and resolution during the reporting period.	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and GM02_CSoC Member Appeals and SFH Report Template.	
11.7.3	Reports with redacted personally identifying information will be made available for public inspection upon request.	P/P for Grievance and Appeals		Full	This requirement is addressed in the Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2.	
11.7.4	The record must be maintained in a manner accessible to LDH and upon request by CMS.	P/P for Grievance and Appeals		Full	This requirement is addressed in Grievance/Appeal/State Fair Hearing Records and Reports Procedure, page 2, and Medicaid: Record Retention, Transport, and Destruction Supplement Policy and Standards, page 2.	

Quality Management

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.	**Quality Management**					
12.1	**Quality Assessment and Performance Improvement Program**					
12.1.1	The Contractor shall maintain an internal QAPI program that complies with state and federal standards specified in 42 CFR §438.200, the Medicaid State Plan and waiver applications relative to the CSoC, and any other requirements as issued by LDH. The Contractor shall:	P/P for QM P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 4.	
12.1.1.1	Establish a QAPI program based on a model of continuous quality improvement using clinically sound, nationally developed and accepted criteria.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 4.	
12.1.1.2	Recognize that the QAPI process shall be data driven, requiring continual measurement of clinical and non-clinical processes driven by such measurements and requiring re-measurement of effectiveness and continuing development and implementation of improvements as appropriate.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 4.	
12.1.1.3	Have sufficient mechanisms in place to assess the quality and appropriateness of care furnished to members with special healthcare needs.	P/P for QAPI		Full	This requirement is addressed in the Child and Adolescent Needs And Strengths (CANS) Comprehensive Multisystem Assessment for Louisiana, the 1915(c) Independent Behavioral Health Assessment form utilized by Magellan, the Comprehensive System of Care (CSoC) Review Report, and the Health Status and Medical Needs Procedure.	
12.1.1.4	Collect data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural).	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 20, and Magellan's Network Development and Management Plan, pages 10-13.	
12.1.1.5	Identify and address health disparities between population groups, such as but not limited to	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 14, and in the	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	quality of care, access to care and health outcomes.				Cultural Competency Program Description, pages 12-13. This requirement is addressed in Magellan's Outcome Evaluation Strategy, page 7, wherein the PAHP identified an opportunity to further explore the disparity in CANS outcomes for members involved in child-serving agencies.	
12.1.2	Detect and address under-and-over utilization of services.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 24, and in the QAPI Work Plan, page 18.	
12.1.2.1	Verify members' receipt of services.	P/P for QAPI		Full	This requirement is addressed in the Medicaid Verification of Services Provided to Members Policy. Evidence of how this verification is carried out is provided in the LA CSoC Verification of Services Questionnaire, which was communicated to members within Magellan's Summer 2019 Member Newsletter.	
12.1.2.2	Monitor subcontracted provider activities to ensure compliance with federal and state laws, regulations, waiver and Medicaid State Plan requirements, the contract, and all other quality management requirements, including a procedure for formal review with site visits. Site visits shall be conducted according to a periodic schedule determined by the Contractor and approved by LDH.	P/P for QAPI P/P for site visits		Full	This requirement is addressed in the Provider Network Ongoing Monitoring Policy, the Network Provider Site Visits Policy, the Provider Monitoring Activities Procedure, and the Wraparound Agency Record Review Monitoring Procedure.	
12.1.2.3	Conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, pages 9 and 24, in the Quality of Care Patient Safety Review Policy, and in the Quality of Care Concern Procedure.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
Fullll12.1.2.6	Develop a performance scorecard (wraparound scorecard) for each wraparound agency to include comprehensive data on a variety of measures.	P/P for QAPI WAA Scorecards		Full	This requirement is addressed in the QAPI Program Description, page 24, and the Wraparound Agency Record Review Monitoring Procedure.	
12.1.2.7	Take appropriate action to address service delivery, provider, or other QAPI issues as they are identified.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 9, Quality of Care Patient Safety Review Policy, and Quality of Care Concern Procedure. This requirement is also addressed in the Quality of Care Concern Reporting Form and QAPI Work Plan.	
12.1.2.8	Have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, subcontracts, members and their families/caregivers, and providers and use the feedback and recommendations to improve performance.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, pages 9-10, Member Experience Survey Policy, Member Satisfaction Survey Procedure, and Medicaid Enrollee Grievances Policy. This requirement is addressed in Magellan's website, their Regional Advisory Conference Evaluation Form, and in agendas for the monthly QI QM and clinical meetings.	
12.1.2.9	Disseminate information about findings and improvement actions taken and their effectiveness to LDH, the CSoC Governance Board, and other participating agencies, members and their families/caregivers, providers, committees, and other key stakeholders and post the information on the Contractor's website in a timely manner.	P/P for QAPI Evidence of dissemination		Full	This requirement is addressed in the QAPI Program Description, page 24, and the State Governance Board presentations, the member newsletters, and on Magellan's website.	
12.1.2.10	Ensure that the ultimate responsibility for the QAPI is with the Contractor and shall not be delegated to subcontractors or network providers.	P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description, page 24.	
12.1.2.11	Participate in the LDH quality committee meetings	LDH Quality Committee	Not applicable as per LDH			

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and other meetings as directed by LDH.	meeting agendas, minutes, and sign-in sheets				
12.1.2.12	Participate in the review of quality findings and take action as directed by LDH. The Contractor shall submit materials to LDH at least three (3) business days prior to the scheduled meeting date.	P/P for QAPI Evidence of timely submission	Not applicable as per LDH			
12.2	**QAPI Committee**					
12.2.1 12.2.1.1 12.2.1.2	The Contractor shall form a QAPI committee that shall, at a minimum include: .1 The Contractor's Medical Director, who must serve as the chair or co-chair and .2 Appropriate Contractor staff representing the various departments of the Contractor organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.	P/P for QAPI Committee Organizational Chart		Full	This requirement is addressed in the QAPI Program Description, pages 8-15.	
12.2.2	QAPI committee responsibilities shall include: .1 Directing and reviewing QI activities; .2 Ensuring QAPI activities take place throughout the organization; .3 Suggesting new and/or improved QI activities; .4 Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members; .5 Conducting quality performance measure profiling; .6 Reporting findings to appropriate executive authority, staff, and departments within the Contractor; .7 Directing and analyzing periodic reviews of members' utilization patterns; .8 Maintaining minutes of all committee and	P/P for QAPI Committee		Full	This requirement is addressed in the QAPI Program Description, pages 8-15 and page 28.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	sub-committee meetings and submitting meeting minutes and agendas to LDH within five (5) business days following the meeting. The Contractor shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting. .					
12.2.3 12.2.3.1	QAPI Program Description, Work Plan and Evaluation .1 The QAPI committee shall develop and implement a written QAPI work plan, which must be submitted to LDH within thirty (30) days of DOA/OSP approval of the signed contract and thereafter at the beginning of each contract year.	P/P for QAPI work plan Evidence of timely submission to LDH		Full	This requirement is addressed in the Quality Improvement Program Policy, QAPI Program Description, page 23, and in the QI Work Plan.	
12.2.3.2	The QAPI work plan, at a minimum, shall:					
12.2.3.1	Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Program Description, pages 9-12.	
12.2.3.2.2	Include the methodology utilizing for collecting data and describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Program Description, page 21, Data Collection and Integration Procedure, and the Provider Monitoring Review Tool. This requirement is also addressed in the Data Collection and Integration Procedure, and the QAPI Work Plan, pages 11 and 13. While compliant with this standard, the PAHP may want to consider including a reference to the Data Collection and	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
					Integration Procedure in the QAPI Work Plan.	
12.2.3.2.3	Specify remediation actions that will be implemented when system performance is less than the required threshold.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan, pages 24-30.	
12.2.3.2.4	Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention's effectiveness.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan.	
12.2.3.2.5	Describe how the Contractor will obtain feedback from providers and members.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan, pages 4 and 15.	
12.2.3.2.6	Describe how the Contractor will collect data on race, ethnicity, gender, age, primary language, and geography and ensure said data is accurate.	P/P for QAPI work plan		Substantial	This requirement is partially addressed in the QAPI Work Plan, pages 12 and 14. There is no reference to how the accuracy of demographic data will be assessed. The Data Collection and Integration Procedure describes how the integrity and accuracy of the data is maintained. **Recommendations:** The PAHP should revise its QAPI Work Plan to reference the Data Collection and Integration Procedure and/or include a description of how demographic data will be assessed for accuracy.	Magellan will update the Work Plan as recommended. The updated QAPI Work Plan will be reviewed/approved during the September, 2019 Louisiana CSoC Quality Improvement Committee (QIC). QIC minutes and documentation are submitted to the LDH within 5 business days of every meeting and, therefore, they will have the updated Work Plan for their records.
12.2.3.2.7	Be exclusive to the CSoC and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.2.3.3	The QAPI work plan at a minimum shall:					
12.2.3.3.1	Include objectives for the contract year, inclusive of associated action steps and timelines.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan.	
12.2.3.3.2.	Include metrics and associated benchmarks for the wraparound agency scorecard.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan. The wraparound agency scorecard metrics are referenced on page 17, with corresponding thresholds in lieu of benchmarks, which are not available.	
12.2.3.3.3	Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the WAAs adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	P/P for QAPI work plan		Full	This requirement is addressed in the QAPI Work Plan, page 17. The Provider Monitoring Program Description describes the Fidelity Monitoring Plan, and data collection tools are used to collect information about the WAAs.	
12.2.3.3.4	Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with NWI standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of WF's demonstration of established wraparound competencies on a quarterly basis.	P/P for QAPI work plan		Full	This requirement is addressed in the Louisiana Wraparound Best Practices Policy and the Healthcare Outcome Evaluation Strategy. Although compliant with this standard, the PAHP may want to consider including their plan to evaluate the implementation of high-fidelity wraparound in accordance with NWI standards, or referencing the Wraparound Best Practice Policy in the QAPI Work Plan.	
12.2.3.4	The QAPI committee shall submit an annual QAPI	Not applicable as per LDH				

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.2.3.4.1 12.2.3.4.2	evaluation to LDH no more than three (3) months following the end of each contract year that includes, but is not limited to: .1 Result of QAPI activities and .2 Findings that incorporate prior year information and contain an analysis of any demonstrable improvements in the quality of care;					
12.3	**CSoC Outcome Evaluation**					
12.3.1	The Contractor shall develop and implement a comprehensive strategy to determine the effectiveness of the CSoC program for different member population groups, such as but not limited to gender, race, age, diagnosis and system involvement, and for members receiving different support and services, such as but not limited to CSoC waiver peer support services and other behavioral health interventions. The strategy must be submitted to LDH for approval within 90 days of the contract go-live date and upon revision.	P/P for CSoC Outcome Evaluation		Full	This requirement is addressed in the Healthcare Outcome Evaluation Strategy.	
12.4	**Medicaid Home and Community-Based Waivers**					
12.4.1 12.4.1.1	Home and Community-Based Setting Rule .1 The Contractor shall ensure 1915(c) and 1915(b)(3) members reside and receive services in settings that are home and community-based, as defined at 42 CFR 441.301(c)(4), and any subsequent guidance issued by LDH and/or CMS.	P/P for HCB Waiver Services		Full	This requirement is addressed in the QAPI Program Description, page 25.	
12.4.1.2	The Contractor shall ensure provider and member enrollment staff receive training and are knowledgeable about the home and community-based setting rule, including the settings that are	P/P for HCB Waiver Services	csoc-provider-communication-annual-hcbs-provider-training-final-041619; HCBS Setting	Full	This requirement is addressed in the QAPI Program Description, page 25. Training program reviewed on-site.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	prohibited. Upon certification/recertification and/or credentialing/re-credentialing, the Contractor must assess whether the provider applicant/provider's proposed/current service location comports with the home and community-based setting rule. Providers whose service setting does not comport with the rule shall not be permitted to provide CSoC services.		Rule Requirements for Providers and Wraparound Agency Training			
12.4.1.3	The Contractor shall train waiver providers and Wraparound Facilitators about the home and community-based setting rule requirements, including the settings that are prohibited at least annually.	P/P for HCB Waiver Services Training Materials Sign-in Sheets		Full	This requirement is addressed in the QAPI Program Description, page 25. Training program reviewed on-site.	
12.4.1.4	Prior to enrolling members into the CSoC program, the Contractor shall assess whether the member resides in a prohibited setting. Members who resided in prohibited settings shall not be enrolled into the 1915c waiver. The Contractor may only permit eligible individuals, who reside in an institution (such as an inpatient hospital, nursing facility, IMD, ICF/DD, or PRTF) or other non-HCBS setting (such as a group home, SUD residential treatment setting or any setting on the grounds of or adjacent to a public institution, or any setting located in a building that also provides inpatient institutional treatment), to receive Wraparound Services under the 1915(b)(3) authority for up to ninety (90) days while the participant remains in the institutional/non-HCBS setting for discharge planning purposes to ensure a successful transition to a home and community-based setting and, when clinical eligibility is met, enrollment in the 1915 c waiver.	P/P for CSoC Enrollment		Full	This requirement is addressed in the referral workflow, HCBS Rule-Member Survey, and HCBS Rule-Member Compliance Management.	
12.4.1.5	The Contractor shall monitor members on no less	P/P for HCB Waiver		Full	This requirement is addressed in the HCBS	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	than a quarterly basis to ensure they continue to reside in settings that are home and community-based and notify LDH of any members found to be residing or receiving services in a prohibited setting, and proposed action steps to transition the member to an appropriate setting.	Services			Monthly Monitoring CSoC Spreadsheet Instructions, and in the Plan of Care Review Procedure.	
12.4.1.6	The Contractor shall monitor each waiver providers at least one (1) time per year, using an LDH approved quarterly sampling methodology to ensure they provide services in settings that are home and community-based. The Contractor shall notify LDH of any waiver providers found to be non-compliant with the setting rule and proposed action steps to address non-compliance.	P/P for HCB Waiver Services Evidence of LDH notification if applicable		Full	This requirement is addressed in the QAPI Program Description, pages 25-26, the Provider Network Monitoring Review Procedure, and in the Provider Monitoring Review Tools (network monitoring tool tab, rows 48-53.	
12.4.2 12.4.2.1	Waiver Performance Measures The Contractor shall have systems in place to measure and improve its performance in meeting the 1915(c) waiver assurances that are set forth in 42 CFR §441.301 and §441.302. The Contractor shall collect data, perform data analysis, and report data for the performance measures identified in the current 1915(c) application and in accordance with the specifications set forth within, as directed by LDH. In addition, the Contractor shall report data for the 1915(b)(3) population utilizing the specified 1915(c) measures. Data shall be available in both individual-level and aggregate form for all performance measures, as requested by LDH.	P/P for Waiver Performance Measures		Full	This requirement is addressed in the QAPI Program Description, page 25, and in the QAPI Work Plan, pages 20-24.	
12.4.2.2	The Contractor shall report individual-level remediation actions taken for critical incidents involving substantiated abuse, neglect, exploitation, and death to LDH.	P/P for Waiver Performance Measures		Full	This requirement is addressed in the QAPI Work Plan, pages 21 and 28, the Adverse Incident Procedure, the Adverse Incident Form, and the Adverse Incident Report Template.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.4.2.3	When performance falls below the LDH established threshold for any measure, the Contractor shall conduct further analysis to determine the cause and complete a quality improvement project (QIP), subject to the review and approval of LDH. The QIP will be due to LDH no later than 30 days following the reporting period. In addition, the QIP must measure the impact to determine whether the project was effective. If the project is deemed not effective by LDH, the Contractor shall submit a revised QIP no later than fifteen (15) days following notification from LDH, which specifies the interventions the Contractor will employ to improve performance.	P/P for Waiver Performance Measures P/P for QIPs		Full	This requirement is addressed in the QAPI Program Description, page 25, and in the QAPI Work Plan, pages 25-30.	
12.4.3	Quality Reports and Performance Measures The Contractor shall collect data, perform data analysis, and report data for the performance measures identified in the CSoC Quality Improvement Strategy (QIS) prepared by LDH and in accordance with the frequency identified in said document and the methodology approved by LDH.	P/P for Quality Reports and Performance Measures		Full	This requirement is addressed in the QAPI Program Description and in the QAPI Work Plan, pages 20-24.	
12.4.3.2	The Contractor shall submit a CAP within thirty (30) calendar days of notification by LDH, incorporating a timetable within which it will correct deficiencies identified when it fails to meet performance measure benchmarks set by LDH. LDH must prior approve the CAP and will monitor the Contractor's progress in correcting deficiencies.	P/P for Quality Reports and Performance Measures P/P for CAPs		Full	This requirement is addressed in the QAPI Program Description, page 27, and in the QAPI Work Plan, pages 20-24.	
12.4.3.3	The Contractor shall provide weekly reports of wraparound referrals and enrollment from the WAAs to LDH.	P/P for Quality Reports and Performance Measures Evidence of provision of reports		Full	This requirement is addressed in the QAPI Program Description, page 27, and evidenced in the CSoC Referral Report dated 5/17/19.	
12.4.3.4	The Contractor shall collect data from the WAAs	P/P for data collection from		Full	This requirement is addressed in the QAPI	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 be utilized in various reports including but not limited to the WAA data spreadsheet which includes information on client progress and outcomes in identified domains such as schools and communities (use of natural supports, Out of Home placements, status at discharge, hospitalizations, etc.)	WAAs			Program Description, page 27 and in the CSoC WAA data spreadsheet.	
12.4.3.5	The Contractor shall submit Quantitative reports that shall include a summary table that presents data over time including monthly, quarterly, and/or year-to-date summaries as directed by LDH.	Quantitative reports		Full	This requirement is addressed in the QAPI Program Description, page 27, and in the Adverse Incident Report Template.	
12.4.3.5.1	Each report must include the analytical methodology (e.g. numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by LDH), as requested by LDH. LDH reserves the right to validate all reporting.	P/P for Quantitative reports		Full	This requirement is addressed in the QAPI Program Description, page 27, and in the Magellan CSoC Report Cover Sheet.	
12.4.3.6	The Contractor shall adhere to the current technical specifications developed by the measure steward (i.e., the entity that developed the measure) and approved by LDH. LDH reserves the right to validate all reporting.	Not applicable as per LDH				
12.4.3.7	The Contractor shall stratify data reports as directed and requested by LDH in response to legislative, media or other external requests in accordance with standard practices for ad hoc reporting.	P/P for Quantitative reports		Full	This requirement is addressed in the QAPI Program Description, page 27.	
12.4.3.8	The Contractor shall utilize systems, operations, and performance monitoring tools and/or automated systems for monitoring; the tools and reports shall be flexible and adaptable to changes	P/P for Quantitative reports		Full	This requirement is addressed in the QAPI Program Description, pages 27-28, the Magellan TRR Web Portal Screenshots, and the Provider Monitoring Review Tools.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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 quality measurements required by LDH.					
12.5	**Performance Improvement Projects**					
12.5.1	The Contractor shall establish and implement an ongoing program of PIP that focus on clinical and non-clinical performance measures as specified in 42 CFR 438.240.	P/P for PIPs		Full	This requirement is addressed in the QAPI Program Description, page 26, and the Follow-up After Hospitalization (FUH) performance measures being utilized in the PAHP's PIP.	
12.5.2	The Contractor shall perform a minimum of one LDH-approved PIP. LDH may require up to two additional projects for a maximum of three projects.	P/P for PIPs		Full	This requirement is addressed in the QAPI Program Description, page 26, and the Follow-up After Hospitalization PIP the PAHP has initiated.	
12.5.3	The Contractor shall ensure that CMS protocols for PIPs are followed and that all steps outlined in the CMS protocols for PIPs are documented.	P/P for PIPs		Full	This requirement is addressed in the QAPI Program Description, page 26, and the PIP reporting template the PAHP populated for their 2019-2021 PIP submission.	
12.5.4	The Contractor shall provide a general and detailed description of each PIP to LDH within three (3) months of the signed contract date and within three (3) months of the beginning of each contract year thereafter, unless otherwise directed by LDH.	P/P for PIPs Evidence of timely submission		Full	This requirement is addressed in the QAPI Program Description, page 26, and the PAHP's 2019 PIP submission.	
12.5.4.1	Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.	P/P for PIPs		Full	This requirement is addressed in the QAPI Program Description, page 26, and the PAHP's 2019 PIP submission.	
12.5.4.2	If CMS specifies Performance Improvement Projects, the Contractor will participate and this will count toward the state-approved PIPs. In addition, if CMS identifies more than the contract required number of PIPs, the Contractor shall comply.	P/P for PIPs Evidence of CMS and/or LDH communication if applicable		Full	This requirement is addressed in the QAPI Program Description, page 26.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
12.5.4.3	The Contractor shall submit PIP data analysis to LDH, using a format approved by LDH and at the frequency determined by LDH.	P/P for PIPs		Full	This requirement is addressed in the QAPI Program Description, page 26, and the PAHP's 2019 PIP submission.	
12.5.4.4 12.5.4.4.1 12.5.4.4.2 12.5.4.4.3 12.5.4.4.4	The Contractor shall submit PIP outcomes annually to LDH, using a format approved by LDH, including but not limited to: .1 Results with quantifiable measures; .2 Analysis with time period and the measures covered; .3 Analysis and identification of opportunities for improvement; and .4 An explanation of all interventions to be taken with associated anticipated timelines.	P/P for PIPs Evidence of timely submission		Full	This requirement is addressed in QAPI Program Description, page 26.	
12.6	**Provider Monitoring**					
12.6.1 12.6.1.1 12.6.1.2 12.6.1.3 12.6.1.4 12.6.1.5 12.6.1.6 12.6.1.7	The Contractor shall develop and implement a plan for monitoring providers, including direct care staff, and facilities to ensure quality of care and compliance with waiver requirements. The Contractor shall submit the plan to LDH for approval within thirty (30) days of contract execution, upon revision and annually thereafter. The plan must include: 1. Review criteria for each applicable provider type; 2. Tools to be used; 3. Sampling approach; 4. Frequency of review; 5. Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis; 6. Plan for ensuring corrective actions are implemented appropriately and timely by providers; and	P/P for provider monitoring		Full	This requirement is in the QAPI Program Description, pages 23-24, the Provider Network Ongoing Monitoring Policy, the Network Provider Site Visits Policy, and the CSoC Provider Monitoring Review Tools Listing.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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. Inter-rater reliability methods.					
12.6.2	The Contractor must adhere to the minimum sampling approach described in the approved waiver authority document or as required by LDH.	P/P for provider monitoring		Full	This requirement is addressed in the Provider Network Monitoring Review Procedure, the Treatment Record Review Procedure, and in the Wraparound Agency Record Review Monitoring Procedure.	
12.6.3 12.6.3.1 12.6.3.2 12.6.3.3 12.6.3.4 12.6.3.5 12.6.3.6 12.6.3.7 12.6.3.8 12.6.3.9 12.6.3.10 12.6.3.11	The Contractor's review criteria shall address the following areas at a minimum: 1. Quality of care consistent with professionally recognized standards of practice; 2. Adherence to clinical practice guidelines; 3. Member rights and confidentiality, including advance directives and informed consent; 4. Cultural competency; 5. Patient safety; 6. Compliance with waiver requirements; 7. Compliance with adverse incident reporting requirements; 8. Appropriate use of restraints and seclusion, if applicable; 9. Treatment planning components, including criteria to determine if 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; 10. Continuity and coordination of care, including adequate discharge planning; and 11. Adherence to SAMHSA Peer Worker Core Competencies for FSO peer staff.	P/P for provider monitoring		Full	This requirement is addressed in the Provider Monitoring Review Tool Listing. Sub-elements 1 and 2 are demonstrated in the Quality of Care Patient Safety Review Policy, and the Quality of Care Concern Procedure and Reporting Form.	
12.6.4	The Contractor shall ensure that an appropriate corrective action is taken when a provider or their	P/P for provider monitoring P/P for CAPs		Full	This requirement is addressed in the Provider Monitoring Activities Procedure, the	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	staff furnishes inappropriate or substandard services, does not furnish a service that should have been furnished, or is out of compliance with federal and state regulations. The Contractor shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.				Provider Network Monitoring Review Procedure, and in the Treatment Record Review Procedure.	
12.6.5	The Contractor shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for specialized behavioral health services.	Evidence of timely submission		Full	This requirement is addressed in the Provider Network Monitoring Review Procedure, Treatment Record Review Procedure, and in the Wraparound Agency Record Review Monitoring Procedure. Submission of the reports was confirmed on-site by OBH.	
12.7	**Member Satisfaction Surveys**					
12.7.1	The Contractor shall survey members on an annual basis to assess member satisfaction with the quality, availability, and accessibility of care and experience with his/her providers and the Contractor.	P/P for Member Satisfaction Surveys		Full	This requirement is addressed in the Member Satisfaction Survey Procedure. The survey itself is conducted outside the review period.	
12.7.2 12.7.2.1 12.7.2.2	The survey shall provide a statistically valid sample of members who have at least three (3) months of continuous enrollment. .1 The survey tool and methodology must be approved by LDH prior to administration. LDH reserves the right to require the use of a LDH-issued survey tool. .2 The survey results shall be provided to LDH annually.	P/P for Member Satisfaction Surveys		Full	This requirement is addressed in the Member Satisfaction Survey Procedure. The survey itself is conducted outside the review period.	
12.8	**Quality Reviews**					
12.8.1 12.8.1.1	The Contractor and its network providers shall fully cooperate in quality reviews conducted by LDH or its designee.	P/P for Quality Reviews		Full	This requirement is addressed in the QAPI Program Description, page 25.	

Quality Management						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	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
	.1 The Contractor shall comply with external independent reviews of quality outcomes, timeliness of, and access to the services covered under this contract. The external review may include, but not be limited to all or any of the following: treatment record review, performance improvement projects and studies, surveys, calculation and audit of quality and utilization indicators, data analyses and review of individual cases. .2 The Contractor shall make available records and other documentation and be fully responsible for obtaining records from subcontractors, as directed by LDH. .3 The Contractor and its providers shall cooperate with and participate, as required, in SAMHSA core reviews of services and programs funded through federal grants.					
12.8.2	The Contractor shall use quality review findings to improve the QAPI program and shall take action to address identified issues in a timely manner, as directed by LDH.	P/P for Quality Reviews P/P for QAPI		Full	This requirement is addressed in the QAPI Program Description.	
12.8.3	The standards by which the Contractor will be surveyed and evaluated will be at the sole discretion and approval of LDH. If deficiencies are identified, the Contractor must formulate a CAP, within thirty (30) calendar days of notification by LDH, incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. LDH must prior approve the CAP and will monitor the Contractor's progress in correcting deficiencies.	P/P for Quality Reviews Evidence of timely communication if applicable		Full	This requirement is addressed in the QAPI Program Description, page 25.	

Program Integrity

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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	**PROGRAM INTEGRITY**					
13.1	**Fraud, Waste and Abuse Prevention**					
13.1.1	General Requirements					
13.1.1.1	The Contractor shall comply with all state and federal laws and regulations relating to fraud, waste and abuse and LDH established policies and procedures.					
13.1.1.2	The Contractor shall develop and maintain internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste and abuse activities.	P/P for Fraud, Waste, And Abuse		Full	This requirement is addressed in Medicaid: Program Integrity and Compliance Program.	
13.1.1.3	Such policies and procedures must be in accordance with state and federal regulations. Contractor shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Contractor in preventing and detecting potential fraud and abuse activities.	P/P for Fraud, Waste, And Abuse		Full	This requirement is addressed in Medicaid: Program Integrity and Compliance Program Policy and Standards, pages 4 to 6.	
13.1.1.4	The Contractor shall require that all providers and all subcontractors take such actions as are necessary to permit the Contractor to comply with Program Integrity, Fraud, Waste, and Abuse Prevention requirements listed in the contract. To the extent that the Contractor delegates oversight responsibilities to a third party, the Contractor shall require that such third party complies with provisions of the contract relating to Fraud, Waste, and Abuse Prevention. Although all network providers with whom the Contractor	P/P for PI P/P for Fraud, Waste, And Abuse Example of provider/subcontractor agreements containing required language		Full	This requirement is addressed in the provider handbook, pages 44 to 48, and provider contracts.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	contracts are enrolled in the program and subject to regulations, the Contractor agrees to require, via contract, that such providers comply with regulations and any enforcement actions directly initiated by LDH under its regulations, including but not limited to termination and restitution. The Contractor shall require program integrity disclosure on provider enrollment forms as mandated by LDH. LDH reserves the right to update enrollment forms periodically and require immediate use of the updated form.					
13.1.1.5	The Contractor, including the Contract Compliance Coordinator and Program Integrity Compliance Officer, shall meet with LDH and the Medicaid Fraud Control Unit (MFCU) upon LDH request, to discuss program integrity issues, fraud, waste, abuse, and overpayment issues.	Meeting minutes/ sign-in sheets if applicable		Full	This requirement is addressed in Jan PI/SIU Call Invite.	
13.1.1.6	In accordance with 42 CFR §438.608(a)(1), the Contractor shall establish a compliance program, and designate a compliance officer and a regulatory compliance committee on the Board of Directors that have the responsibility and authority for carrying out the provisions of the compliance program. The Compliance Officer shall answer directly to the Chief Executive Officer and Board of Directors.	P/P for compliance program Organizational Chart		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards.	
13.1.1.7	The Contractor shall maintain a self-balancing set of records in accordance with Generally Accepted Accounting Procedures. The Contractor agrees to maintain supporting financial information and documents that are adequate to ensure that payment is made in accordance with applicable federal and state requirements, and are sufficient to ensure the accuracy and validity of Contractor					

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	invoices. Such documents, including all original claim forms, shall be maintained and retained by the Contractor for a period of ten (10) years after the contract expiration date or until the resolution of all litigation, claims, financial management reviews or audits pertaining to the contract, whichever is longer.					
13.1.1.8	The Contractor shall not have restrictions on the right of the State and federal governments to conduct inspections and audits as deemed necessary to ensure quality, accuracy, appropriateness or timeliness of services and the reasonableness of their costs. LDH, state government, federal government, or their designees including but not limited to the Attorney General, Office of the Inspector General, Louisiana Legislative Auditor, and Comptroller General, may inspect and audit any financial and/or other records of the entity, network providers or its subcontracts. Upon reasonable notice (as defined by LDH based upon the request), the Contractor shall provide the officials and entities identified in this section on Program Integrity with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the scope of work. The Contractor agrees to provide the access described within the state regardless of where the Contractor maintains such books, records, and supporting documentation. The Contractor further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this section. The Contractor	P/P for Fraud, Waste, and Abuse P/P for external audits		Full	This requirement is addressed in Payment Suspension Review, Request, and Response, And SIU Overpayments Appeals/Rebuttal Request, Response.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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 require its Contractors to provide comparable access and accommodations.					
13.1.1.9	The Contractor and its employees shall cooperate fully and assist the State and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, waste or abuse. Such cooperation may include participating in periodic fraud and abuse training sessions, meetings, and joint reviews of network providers or members. The Contractor will cooperate with any independent verification and validation Contractor or quality assurance Contractor acting on behalf of LDH. LDH or any authorized federal or state agency for a period of ten (10) years from the expiration date of the contract (including any extensions to the contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the contract and any other applicable rules. The Contractor and its network providers shall make all program and financial records and service delivery sites open to the representative or designees of the State or federal agencies authorized to review matters related to service delivery as specified by the Contract, and shall provide originals and/or copies of all records and information requested at no charge.	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, and Payment Suspension Review, Request and Response, and SIU Overpayments Appeals/Rebuttal, Request, Response.	
13.1.1.10	The Contractor shall ensure compliance with and/or outline CAP for any finding of noncompliance based on law, regulation, audit requirement, or generally accepted accounting principles or any other deficiency contained in any audit, review, or inspection conducted. This action shall include the Contractor's delivery to LDH, for	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in Medicaid: Program Integrity and Compliance Program Policy and Standards, and discussion with the PAHP during on-site visit.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	approval, a CAP that addresses deficiencies identified in any audit(s), review(s), or inspection(s) shall be submitted within thirty (30) calendar days of the close and final report of the audit(s), review(s), or inspection(s). Upon receipt and review of the submitted CAP, LDH will notify the Contractor that its CAPs are accepted, rejected, or require modification of any portion found to be unacceptable. The Contractor shall bear the expense of compliance with any finding of non-compliance under the contract.					
13.1.1.11	Upon LDH request, the Contractor shall provide a copy of those portions of the Contractor's, its subcontractors and its provider's internal audit reports relating to the services and deliverables provided to LDH under the contract.	P/P for internal audits Evidence of submission if applicable		Full	This requirement is addressed in MCFU Request.	
13.1.1.14 13.1.1.14.1 13.1.1.14.2 13.1.1.14.3 13.1.1.14.4 13.1.1.14.5 13.1.1.14.6 13.1.1.14.7	The Contractor shall require all employees to complete and attest to training modules within thirty (30) days of hire and annually related to the following in accordance with federal and state laws: 1. Contractor Code of Conduct Training; 2. Privacy and Security – Health Insurance Portability and Accountability Act; 3. Fraud, waste, and abuse identification and reporting procedures; 4. Federal False Claims Act and employee whistleblower protections; 5. Procedures for timely consistent exchange of information and collaboration with LDH; 6. Organizational chart including the Program Integrity Compliance Officer and program integrity staff and investigator(s); and 7. Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant state and	P/P for employee training Training Materials Sign-in sheets		Full	This requirement is addressed by on-site review of training materials and sign in sheets found on the PAHP's website.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	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 the Department, the Department of Health and Human Services (HHS), CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its Departments.					
13.1.1.15 13.1.1.15.1 13.1.1.15.2 13.1.1.15.3	The Contractor 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 Contractor shall not take any of the following actions as they specifically relate to Medicaid claims: 4. Contact the subject of the investigation about any matters related to the investigation; 5. Enter into or attempt to negotiate any settlement or agreement regarding the incident; or 6. Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	P/P for Fraud, Waste, and Abuse		Substantial	This requirement is addressed in PI 145 report. Missing from documentation are the requirements that: 4. Contract the subject … 5. Enter into or attempt … 6. Accept any monetary … " **Recommendation:** The PAHP should include discussion of the following in written policy: "The Contractor shall not take any of the following actions as they specifically relate to Medicaid claims: 4. Contract the subject … 5. Enter into or attempt … 6. Accept any monetary … "	Magellan's FWA policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.1.2	Fraud, Waste and Abuse Compliance Plan					
13.1.2.1	In accordance with 42 CFR §438.608(a), the Contractor and any subcontractors, to the extent	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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 subcontractor is delegated responsibility for coverage of services and payment of claims under the contract, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud, Waste and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, waste, and abuse in the administration and delivery of services.	Fraud, Waste, and Abuse Compliance Plan			Program Policy and Standards, Extended to Subcontractors, page 6.	
13.1.2.2	The Contractor shall establish and implement procedures and a system with dedicated staff responsible for routine internal monitoring and auditing of compliance risks, promptly responding to compliance issues, investigating compliance problems identified, and correcting compliance issues to reduce the potential for recurrence, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, and ongoing compliance with the requirements of the contract.	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 7.	
13.1.2.3	The Contractor shall submit the written Fraud, Waste and Abuse Compliance annually. The Contractor shall submit requests for revision(s) to the Plan in writing to LDH-OBH for approval at least thirty (30) days prior to Plan implementation of such revision(s). LDH-OBH, at its sole discretion, may require that the Contractor modify its compliance plan. The Fraud, Waste and Abuse Compliance Plan shall include the following:	Evidence of timely submission		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards.	
13.1.2.3.1	Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Code Of Conduct.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.1.2.3.2	Effective lines of communication between the Program Integrity Compliance Officer and Contractor's employees, providers and subcontractors;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 4 and page 10.	
13.1.2.3.3	Procedures for ongoing monitoring and auditing of the Contractor's systems, including, but not limited to, claims processing, encounters, billing and financial operations, member services, continuous quality improvement activities, and provider activities;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 13.	
13.1.2.3.4	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity 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;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 21, and member handbook, page 24.	
13.1.2.3.5	A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, pages 13 to 15.	
13.1.2.3.6	Enforcement of standards through well-publicized disciplinary guidelines (e.g., member/provider manuals, trainings, newsletters, bulletins);	P/P for Fraud, Waste, and Abuse Disciplinary Guidelines		Full	This requirement is addressed in Employee Discipline for Compliance Related Matters Policy and Standards.	
13.1.2.3.7	Provisions for internal monitoring and auditing of the Contractor's providers, subcontractors, employees, and others;	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, pages 15 to 16.	
13.1.2.3.8	Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to the contract;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, pages 15 to 16.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.1.2.3.9	Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan Evidence of timely communication		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 16.	
13.1.2.3.10	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; and	P/P for Fraud, Waste, and Abuse P/P for internal and external audits		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, pages 13 to 16.	
13.1.2.3.11	Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan P		Full	This requirement is addressed in the False Claims Laws and Whistleblower Protections Policy and Standards, page 7, and in discussions with the PAHP during on-site visit.	
13.1.2.4	The Contractor shall establish policies and procedures for referral of suspected Fraud, Waste and Abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process will be developed to expedite information for appropriate disposition.	P/P for Fraud, Waste, and Abuse		Minimal	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 16, and in the 145 Report template. Missing from the documentation is a standardized referral process. **Recommendation:** The PAHP should develop policies and a standardized procedure for referral of suspected Fraud, Waste, and Abuse to LDH.	Although Magellan's Program Integrity Referral Form is currently used to report suspected FWA, our Program Integrity & Compliance policy will be updated to reflect IPRO's recommendation by 8/31/19. A workflow will be created to illustrate the process, as well.

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.1.2.6	Comply with LAC 50:I.Chapter 41 relative to the SURS;	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards.	
13.1.2.7	The Contractor shall create and disseminate written materials for the purpose of educating employees, managers, providers, subcontractors and subcontractors' employees about healthcare fraud laws, the Contractor's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of employees to act and be protected as whistleblowers. The Contractor's education materials shall comply with all requirements of §1902(a)(68) of the Social Security Act regarding Employee Education About False Claims Recovery. This information shall also be contained in any employee handbook;	P/P for Fraud, Waste, and Abuse P/P for written materials Example educational materials		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 4, and on the PAHP's website.	
13.1.2.8	The Contractor shall establish written policies for all employees (including management), providers and of any subcontractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section §1902(a)(68)(A) of the Social Security Act and the Louisiana Medical Assistance Program Integrity Law (MAPIL). Adherence to the False Claims Act ("FCA") which, in pertinent part, imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false in order to obtain payment from the government, or fraudulently retains government funds (31 U.S.C. §3729 through §3733); and	P/P for Fraud, Waste, and Abuse P/P for False Claims Act		Full	This requirement is addressed in the False Claims Laws and Whistleblower Protections Policy and Standards.	
13.1.2.10	A procedure for conducting explanation of benefits as outlined in Section 7 of this contract;	P/P for explanation of benefits		Full	This requirement is addressed in EOB Quarterly Attestation.	
13.1.2.11	Description of effective training and education for	P/P for Fraud, Waste, and		Full	This requirement is addressed in review of	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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 Compliance Officer, the organization's employees, Contractor providers and members to ensure that they know and understand the provisions of the Fraud, Waste and Abuse Compliance Plan and know about fraud and abuse and how to report it;	Abuse Fraud, Waste, and Abuse Compliance Plan Training material			website training materials during on-site visit.	
13.1.2.12	A toll-free Provider Compliance Hotline phone number for members and providers to report suspected fraud and/or abuse. This hotline shall be separate from the Contractor's toll-free member and provider toll-free phone number(s). The Provider Compliance Hotline may utilize an interactive voice response (IVR) system with options that are user-friendly to callers and include a decision tree illustrating IVR system and expected duration times of navigating the IVR system to reach a live person. The issues reported through the Provider Compliance Hotline, corrective actions taken, and final results must be reported annually to LDH-OBH in the Fraud, Waste and Abuse Compliance Plan, or more frequently upon request of LDH-OBH. The Contractor's toll-free Provider Compliance Hotline number and accompanying explanatory statement shall be distributed to its members and providers through its Member and Provider Handbooks;	P/P for Fraud, Waste, and Abuse P/P for toll-free Provider Compliance Hotline		Full	This requirement is addressed in the provider handbook, page 48, and member handbook, page 22.	
13.1.2.13	The Contractor shall require and has procedures for a network provider to report to the Contractor when it has received an overpayment, and to return the overpayment to the Contractor within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.	P/P for overpayment		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 25.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.2	**Contractor Prohibited Relationships**					
13.2.1	As required in 42 CFR §455.104(a), the Contractor shall provide LDH with full and complete information on the identity of each person or corporation with an ownership interest of five percent (5%) or greater in the Contractor, or any subcontractor in which the Contractor has five percent (5%) or more ownership interest. The Contractor shall also provide such required information including, but not limited to financial statements, for each person or entity with ownership or controlling interest of five percent (5%) or greater in the Contractor and any of its subcontractors, including all entities owned or controlled by a parent organization. This information shall be provided to LDH on the LDH approved Contractor Disclosure Form within thirty (30) days of DOA/OSP approval of the signed contract and whenever changes in ownership occur.	P/P for conflict of interest		Minimal	This requirement is addressed in the Conflicts of Interest Policy and Standards, page 7. However the documents provided do not address reporting ownership interest to LDH within 30 days. **Recommendation:** The PAHP should incorporate contractual requirement to report ownership interest to LDH within 30 days into policy.	Magellan's Conflict of Interest policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.2.2	In accordance with 42 CFR §438.610, the Contractor is prohibited from knowingly having an employment or contractual relationship with:					
13.2.2.1 13.2.2.1.1 13.2.2.1.2 13.2.2.1.3 13.2.2.1.4 13.2.2.1.5	An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the federal regulations or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. The Contractor shall comply with all applicable provisions of 42 CFR §438.608 and §438.610 pertaining to debarment and/or suspension. The Contractor shall screen all	P/P for background screening		Full	This requirement is addressed in Employment Background Investigations, page 4. Missing from the documentation is screening using the LAALS website. **Recommendation:** The PAHP should explicitly indicate in policy that the Louisiana Adverse Actions List Search (LAALS) is used when screening employees.	Magellan's Employment Background Investigations policy will be updated to reflect IPRO's recommendation by 8/31/19.

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	employees to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or any federal healthcare programs. To help make this determination, the Contractor shall conduct screenings to comply with the requirements set forth at 42 CFR §455.436 and search at minimum the following sites: .1 Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) http://exclusions.oig.hhs.gov/ ; .2 Louisiana Adverse Actions List Search (LAALS) https://adverseactions.dhh.la.gov/ ; .3 The System for Award Management (SAM) https://www.sam.gov/index.html/; .4 National Practitioner Data Bank http://www.npdb-hipdb.hrsa.gov/index.jsp and .5 Other applicable sites as may be determined by LDH. The Contractor 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 immediately reported to LDH. An attestation certifying checks are completed on a monthly basis by the 15th of each month is required. See Section 1128A(a)(6) of the Social Security Act and 42 CFR §1003.102(a)(2). Any individual or entity that employs 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					

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	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.					
13.2.2.2	An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.	P/P for background screening		Full	This requirement is addressed in the Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors) Policy and Standards.	
13.2.3 13.2.3.1 13.2.3.2 13.2.3.3 13.2.3.4 13.2.3.5	In addition to the Contractor, the following shall also be subject to the prohibitions of Section 13.2.2: .1 A director, officer, or partner of the Contractor; .2 A subcontractor of the Contractor; .3 A network provider; .4 A person with beneficial ownership of five percent (5%) or more of the Contractor's equity; or .5 A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services which are significant and material to the Contractor's obligations.	P/P for background screening		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 24.	
13.2.4	The Contractor shall notify LDH within three (3) days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C.	Evidence of timely notification if applicable		Not applicable		

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	§1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.					
13.3	**Criminal Background Checks and Information on Persons Convicted of Crimes**					
13.3.1	The Contractor shall comply with LDH Policy No. 47.1 , "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. The Contractor 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 the contract.	P/P for Criminal History Records Check of Applicants and Employees		Full	This requirement is addressed in the Employment Background Investigations Policy and Standards.	
13.3.2	The Contractor must screen all employees and subcontractors to determine whether any of them have been excluded from participation in federal healthcare programs. The HHS-OIG website, which can be searched by the names of any individual, can be accessed at the following URL: http://www.oig.hhs.gov/fraud/exclusions.asp.	P/P for Criminal History Records Check of Applicants and Employees		Full	This requirement is addressed in the Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors) Policy and Standards, page 9.	
13.3.3	The Contractor shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of the contract.	P/P for Criminal History Records Check of Applicants and Employees		Not applicable	Did not occur during review period.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.4	**Excluded Providers**					
13.4.1	FFP is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services as specified in 42 CFR §1001.1901.	P/P for background screening		Full	This requirement is addressed in the Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors) Policy and Standards, page 7.	
13.4.2	The Contractor is responsible for the return to the State of any payments made for services rendered by an excluded provider.	P/P for return of payments		Minimal	This requirement is addressed in the Administration of Claims Overpayment Recovery Policy and Standards and Medicaid: Program Integrity and Compliance Program, page 25. Missing from the documentation provided is the requirement that the contractor is responsible for the return to the state of any payments made for services rendered by an excluded provider. **Recommendation:** The PAHP should include in policy that the contractor is responsible for the return to the state of any payments made for services rendered by an excluded provider.	Magellan's Administration of Claims Overpayment Recovery policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.4.3 13.4.3.1	The Contractor shall not contract with or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 (42 U.S.C. §1320a-7) or §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 facility license or certification, or individual practitioner license;	P/P for contracting requirements		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Procedure, page 23.	
13.4.4	Exclusion from the Medicaid program;	P/P for contracting		Full	This requirement is addressed in the	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	.1 Termination from the Medicaid program; .2 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review (SURS) Rule (LAC 50:I.Chapter 41); .3 Provider fails to timely renew its Louisiana issued facility license and/or federal certification; or .4 The Louisiana Attorney General's Office has seized the assets of the network provider.	requirements			Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers & Vendors) Policy and Standards.	
13.5	**Program Integrity Reporting and Investigating Suspected Fraud and Abuse**					
13.5.1	In accordance with 42 CFR §455.1(a)(1) and §455.17, the Contractor shall be responsible for promptly reporting suspected fraud, waste, and abuse information to the Louisiana 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). Additionally, the Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor, an Contractor employee, or network providers 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 Contractor or a Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	P/P for Fraud, Waste, and Abuse Evidence of timely reporting if applicable		Substantial	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards on page 16. Missing is reference to the time frame (3 days) for reporting suspected fraud, waste, and abuse to the Louisiana Office of Attorney General, MFCU, and LDH. **Recommendation:** The PAHP should include in policy which agencies and the time frame, for reporting suspected fraud, waste, and abuse.	Magellan's Program Integrity & Compliance Program policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.5.2	The Contractor shall report to LDH-OBH and the LDH Program Integrity Unit any program integrity-related (fraud, integrity, or quality) adverse action taken on a provider participating in their network.	P/P for Fraud, Waste, and Abuse Evidence of timely reporting if applicable		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the State executes permissive exclusions to terminate a provider for program integrity issues, the public will be notified as required by the regulation at 42 CFR §1002.212.					
13.5.3	The Contractor, through its Compliance Officer, has an affirmative duty to report all activities on a quarterly basis to LDH. If fraud, waste, abuse, and overpayment issues are suspected, the Contractor compliance officer shall report it to LDH immediately upon discovery. Reporting shall include, but are not limited to:	P/P for Fraud, Waste, and Abuse reporting PI Reports		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	
13.5.3.1	Number of complaints of fraud, waste, abuse, adverse contract terminations (any contractual termination initiated by someone other than a participating provider), and overpayments made to the Contractor that warrant preliminary investigation;	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	
13.5.3.2	Number of complaints reported to the Compliance Officer; and	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	
13.5.3.3 13.5.3.3.1 13.5.3.3.2 13.5.3.3.3 13.5.3.3.4 13.5.3.3.5 13.5.3.3.6	For each complaint that warrants investigation, the Contractor shall provide LDH, at a minimum, the following: .1 Name and ID number; .2 Source of complaint; .3 Type of provider; .4 Nature of complaint; .5 Approximate dollars involved if applicable; and .6 Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the	P/P for Investigations		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	complainant.					
13.5.4	Within three (3) business days of when it is discovered, the Contractor shall report to LDH and the LDH Program Integrity Unit (PIU) any Contractor employee or network provider that has been excluded, suspended, or debarred from any state or federal healthcare benefit program, including any payment history for the individual that occurred subsequent to the effective date of the exclusion as per 42 CFR §455.17.	Evidence of timely reporting		Not applicable	Did not occur during review period.	
13.5.5	The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.	Evidence of timely reporting		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	
13.5.6	The Contractor 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.	Evidence of timely reporting		Full	This requirement is addressed in the P145 Report Fourth Quarter 2018 and First Quarter 2019.	
13.5.7	The Contractor shall confer with LDH Program Integrity before initiating any recoupment or withhold of any program integrity-related funds to ensure that the recovery, recoupment or withhold is permissible.	Evidence of timely communication if applicable		Not applicable	Did not occur during review period.	
13.5.8 13.5.8.1 13.5.8.2 13.5.8.3	The Contractor 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:	P/P for recoupment or withholding of funds		Minimal	This requirement is addressed in Administration of Claims Overpayment Recovery. Missing is discussion of sections .1, .2, and .3. **Recommendation:**	Magellan's Administration of Claims Overpayment Recovery policy will be updated to reflect IPRO's recommendation by 8/31/19.

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	.4 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 .5 The improperly paid funds have already been recovered by the State's Recovery Audit Contractor (RAC) contractor; or .6 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.				The PAHP should include subsections .1, .2, and .3 in policy documents.	
13.5.9	This prohibition described above shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the Contractor obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the Contractor will return the funds to LDH.	P/P for recoupment or withholding of funds		Full	This requirement is addressed in the Administration of Claims Overpayment Recovery.	
13.5.10	The Contractor 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 providers and subcontractors.	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards.	
13.5.11	The Contractor 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	Evidence of timely notification		Full	This requirement is addressed in the PI 145 Fourth Quarter 2018 and First Quarter 2019 PI 145 Report.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the Contractor 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.					
13.5.12	Suspected fraud and abuse in the administration of the program shall be reported to LDH and MFCU;	P/P for Fraud, Waste, and Abuse Evidence of timely notification if applicable		Full	This requirement is addressed in the PI 145 Fourth Quarter 018 and First Quarter 2019 PI 145 Report.	
13.5.13	All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH and MFCU; and	P/P for Fraud, Waste, and Abuse Evidence of timely notification if applicable		Full	This requirement is addressed in the PI 145 Fourth Quarter 018 and First Quarter 2019 PI 145 Report. **Recommendation:** The PAHP should discuss with LDH whether quarterly reporting satisfies this requirement of the contract.	Magellan will discuss this with the LDH at our meeting on 8/22/19.
13.5.14	All confirmed or suspected member fraud and abuse shall be reported immediately to LDH and local law enforcement.	P/P for Fraud, Waste, and Abuse Evidence of timely notification if applicable		Full	This requirement is addressed in the PI 145 Fourth Quarter 018 and First Quarter 2019 PI 145 Report. **Recommendation:** The PAHP should discuss with LDH whether quarterly reporting satisfies this requirement of the contract.	Magellan will discuss this with the LDH at our meeting on 8/22/19.
13.5.15	The Contractor shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of the contract.	P/P for Fraud, Waste, and Abuse reporting Evidence of approval of Fraud Reporting Form		Full	This requirement is addressed in the PI 145 Fourth Quarter 018 and First Quarter 2019 PI 145 Report.	
13.5.16	The Contractor shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report	P/P for Fraud, Waste, and Abuse		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	fraud and abuse by employees, subcontractors, recipients, enrollees, applicants, or providers to LDH or to MFCU, as appropriate.				Program Policy and Standards.	
13.5.17	The Contractor 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.	P/P for Fraud, Waste, and Abuse Investigation Evidence of timely notification if applicable		Full	This requirement is addressed in the PI 145 Fourth Quarter 018 and First Quarter 2019 PI 145 Report.	
13.5.18	The Contractor 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 Contractor 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.	P/P for Fraud, Waste, and Abuse Investigation Evidence of timely notification if applicable		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards and discussion with the PAHP during on-site visit.	
13.5.19	The Contractor and/or its subcontractors shall 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 Contractor is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.	P/P for Fraud, Waste, and Abuse P/P for Payment Suspensions		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards, page 22.	
13.5.20	The State shall not transfer its law enforcement functions to the Contractor.					
13.6	**Right to Review and Recovery by Contractor and LDH**					

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
13.6.1	The Contractor and its subcontractors are responsible for investigating and reporting possible acts of provider fraud, waste, and abuse for all services under the contract.	P/P for Fraud, Waste, and Abuse Investigation		Full	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards.	
13.6.2	The Contractor and its subcontractors shall have the right to audit and investigate providers and enrollees within the Contractor's network for a five (5) year period from the date of service of a claim. The collected funds from those reviews are to remain with the Contractor. The Contractor shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status.	P/P for Fraud, Waste, and Abuse Investigation		Full	This requirement is addressed in the provider handbook, pages 36 to 37.	
13.6.3	All reviews must be completed within one hundred and eighty (180) 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.	P/P for Fraud, Waste, and Abuse Investigation Evidence of timely investigation		Non-compliance	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards. Missing is the requirement that all reviews must be completed within 180 days. **Recommendation:** The PAHP should include in policy the requirement that all reviews must be completed within 180 days of the date the case was opened unless an extension is authorized by LDH.	Magellan's SIU and Program Integrity and Compliance policies will be updated to reflect IPRO's recommendation by 8/31/19.
13.6.4	The Contractor shall confer with LDH before initiating a review to ensure that review and recovery is permissible. Notification of intent to review and/or recover must include at a minimum provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or national drug codes (NDCs) under review, date range for dates of service under review, and	Evidence of communication if applicable		Not applicable	Did not occur during the review period.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the Contractor may proceed with the review. Provision pending LDH guidance.					
13.6.5	Contact with a provider shall be prohibited in instances resulting from suspected fraud, which the Contractor has identified and submitted a referral of fraud to the Department, MFCU or other appropriate law enforcement agency, unless approved by LDH.	P/P for Fraud, Waste, and Abuse Investigation		Minimal	This requirement is addressed in the Medicaid: Program Integrity and Compliance Program Policy and Standards. Missing is the requirement that contact with a provider shall be prohibited in instances resulting from suspected fraud. This was also discussed during the on-site visit. **Recommendation:** The PAHP should include in policy the requirement that contact with a provider shall be prohibited in instances resulting from suspected fraud.	Magellan's Program Integrity and Compliance policy will be updated to reflect IPRO's recommendation by 8/31/19.
13.6.6	If the Contractor fails to collect at least a portion of an identified recovery after three hundred and sixty-five (365) days from the date of notice to the Department, unless an extension or exception is authorized by the Department, the Department or its agent may recover the overpayment from the provider and said recovered funds will be retained by the State.					
13.6.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the Contractor's Program Integrity Compliance Officer or designee. The LDH notification of intent to review must 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	Evidence of timely notification if applicable		Not applicable	Did not occur during the review period.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	amount paid. The Contractor shall have ten (10) business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from LDH. If the State does not receive a response from the Contractor within ten (10) days, the State may proceed with its review.					
13.6.10	In the event the State or its agent investigates or audits a provider or enrollee within the Contractor's network, the Contractor 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 Contractor and State. Document requests do not include treatment records that must be obtained from the provider.	Evidence of timely submission if applicable		Not applicable	Did not occur during the review period.	
13.6.11 13.6.12	LDH shall notify the Contractor and the network provider concurrently of overpayments identified by the State or its agents. The Contractor shall not correct the claims nor initiate an audit on the claims upon notification of the identified overpayment by LDH or its agent unless directed to do so by LDH.					
13.6.13	In the event the provider does not refund overpayments identified by LDH or 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, LDH will notify the Contractor and the Contractor shall initiate a payment withhold on the provider in the amount due to the Department. Upon LDH request, the Contractor shall refund to the State any amounts collected.	P/P for overpayment procedures		Full	This requirement is addressed in the Administration of Claims Overpayment Recovery Policy and Standards, page 3.	

Program Integrity						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
	Any instances of a credit balance would be sustained by the Contractor and/or Department until resolved or dismissed under Department rules.					
13.6.14	In the event LDH or its agent recovers funds from a provider due to an overpayment, the Contractor shall submit corrected encounter data within thirty (30) days upon notification by LDH, and shall not seek additional recovery from the provider for the claims audited by LDH or its agent, unless approved by LDH.					
13.6.15	The Contractor and its subcontractors must enforce LDH directives regarding sanctions on Contractor network providers and enrollees, up to termination or exclusion from the network.	P/P for enforcement of sanctions		Full	This requirement is addressed in email Recent Louisiana Medicaid Program Terminations.	

Audits, Records, and Reports

Audits, Records, and Reports						
Contract Reference	State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)	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
16	**AUDITS, RECORDS, AND REPORTS**					
16.1	**Reporting**					
16.1.1	The Contractor shall comply with all the reporting requirements established by the contract and in accordance with any LDH issued companion and reporting guide(s). As per 42 CFR §438.242(a)(b)(1)-(3), the Contractor shall maintain a management information system (MIS) that collects, analyzes, integrates and reports data that complies with LDH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The Contractor shall collect data on member and provider characteristics and on services furnished to members.	P/P for Reporting		Full	This requirement is addressed in the Louisiana Data Reporting – Louisiana Coordinated System of Care Policy.	