Magellan of Louisiana

2020 Compliance Audit

Review Period: May 01, 2019 – April 30, 2020

Final Report Issued February 2021

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

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ISO 9001:2015 CERTIFIED

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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 2020 annual compliance audit was a partial audit of the PAHP's compliance with contractual requirements during the period of May 1, 2019, through April 30, 2020. Requirements that were not fully compliant in the full 2019 annual compliance audit were reviewed.

This report presents IPRO's findings of the 2020 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 five contractual domains:

1. Member Services
2. Provider Network Requirements
3. Enrollment
4. Grievance and Appeal System
5. Program Integrity

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 for this partial review, file review consisted of the following one area:

1. Appeals

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10

The period of review was May 1, 2019, through April 30, 2020. 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 2020 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 five review tools to reflect the areas for audit. These five tools were submitted to the LDH for approval at the outset of the audit process on April 8, 2020. 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 on July 1, 2020, 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 PAHPs undergoing the audit, with LDH staff in attendance, approximately two weeks after the request packet was sent to the PAHPs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline, and answered any questions posed by PAHP staff.

After the PAHP submitted the required documentation, a team of seven 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 video interviews.

Video Interviews

The video interview component of the audit was composed of two video interview sessions. In the first session conducted on August 14, 2020, file reviews that were considered less than fully compliant based upon review were discussed. In the second session on September 8, 2020, review of elements in each of the five review tools that were considered less than fully compliant based upon review.

Interviews 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 video interviews, 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 for them to attain full compliance.

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

Please note this is a partial review. This table excludes full items from the prior review. Total compliance for each tool (including full items from prior year) will be higher for domains scoring less than 100%. Additionally, some items were new requirements for this review which may have impacted overall percentages

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	1	1	0	0	0	0	100%
Member Grievances and Appeals	5	0	2	3	0	0	0%
Provider Network Requirements	12	11	1	0	0	0	92%
Member Services	3	3	0	0	0	0	100%
Quality Management	1	1	0	0	0	0	100%
Program Integrity	9	9	0	0	0	4	100%
Total	**31**	**25**	**3**	**3**	**0**	**4**	**81%**

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

As presented in **Table 3**, 31 elements were reviewed for compliance. Of the 31 elements, 25 were determined to fully meet the regulations, while 3 substantially met the regulations, 3 minimally met the regulations, and 0 were determined to be non-compliant. Four elements were "not applicable." The overall compliance score indicates that 81% of regulations not fully compliant in the prior review have been addressed by Magellan and are now fully compliant.

IPRO extracted from each of the five 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 LDH that Magellan submits a corrective action plan for new elements determined to be less than fully compliant.

Each of the five review tools and review determinations for each of the elements follow **Table 4**.

Table 4: Deficient 2020 Audit Elements

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element 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	**General 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).	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. 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.	Substantial	This requirement is addressed in the CSoC unit-Quality Improvement – Clinical Management Program Evaluation (page 174). Barriers identified, interventions, and recommendations for 2020 were clearly laid out. A major intervention was the increase in reimbursement rates for LMHPs, prescribers, and short tem respite providers which went into effect in July 2019. **Recommendation** The MCO should continue efforts to monitor the interventions put into place in the latter part of 2019. These include continued engagement of wraparound agencies in training and technical support for staff implementation of the workbook project to improve quality of services provided by non-licensed individuals, and continued monitoring the impact of increased reimbursement rates.	Magellan remains committed to members having 100% desired access to all types of providers and services. We will continue evaluating member needs through satisfaction surveys, geographical data, and service utilization. Although the workbook project was delayed due to the recent pandemic, efforts have begun to distribute the workbooks to providers and a refresher presentation on the utilization the tools is scheduled for November 2020. Provider and service needs remain as agenda items for the monthly meetings

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
						between Magellan, LDH and the Wraparound Agencies. All growth and services needs will continue to be monitored and reported to the Network Strategy Committee.
11.3	**Notice of Adverse Benefit Determination**					
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 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;	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 were compliant. One (1) member did not receive a notice of adverse benefit determination. **Recommendation:** The PIHP should ensure all members who have had benefits denied receive a notice of adverse benefit determination. **MCO Response**: Magellan's non-compliant record resulted from processor error. The following will occur, by 9/30/19: A refresher	Substantial	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. Magellan indicated that new revised letter templates were created to satisfy recommendations from the prior year's audit, were approved by LDH on March 3rd, and put into use after March 4th, 2020. Letter templates prior to this date did not include new revised language. **File Review Results:** One (1) out of ten denial notification letters fully met the requirement. Nine (9) out of 10 clinical denial notification letters satisfied 7 of the 8 requirements because	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element 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 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.		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.		letters were sent to members prior to the revised letter format date of implementation and did not include item number 7 of the regulatory requirement on the letters. **Recommendation** The MCO should ensure that new letter templates, which were approved on March 3rd, 2020, will be used moving forward to meet compliance with this requirement. Nine (9) of the 10 letters reviewed were for cases prior to the new letter template implementation date hence why their letter templates did not address item 7 of this requirement.	
11.4	**Handling of Grievances and Appeals**					
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	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.	Substantial	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. **File Review Results** Nine (9) out of ten appeals files met compliance with the requirement. One (1) out of 10 appeal letters did not meet compliance, and the plan acknowledges this was	Quality control procedures were implemented to ensure integrity of the UM letter templates is maintained as evidenced by the following procedure, letter template, and training

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	provided free of charge and sufficiently in advance of the date by which the Contractor must resolve the appeal.		**Recommendation:** The PIHP should ensure that all members who file an appeal and whose appeal is denied receive a notice of adverse benefit determination. **MCO Response**: 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.		due to a copy and paste error from a case manager. **Recommendation** The MCO should place review processes in place to minimize process errors.	documents. Internal UM Quality Controls Procedure_Approved_09.16.2020 Magellan CSoC UM NOA Template_Quality Controls_10.01.2020.docx Magellan CSoC UM Letter Template Training
11.4.2.4 11.4.2.4.1 11.4.2.4.2	Include, as parties to the appeal: .1 The member and his or her representative; or .2 The legal representative of a deceased member's estate.	P/P for Appeals **File Review**	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. Two (2) of 10 appeals files reviewed were not	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. **File Review Results** One (1) of the ten appeals files met compliance and nine (9) out of the ten appeals did not meet compliance since they used older letter templates.	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element 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. **Recommendation :** For cases where a denial is overturned after an appeal, the PIHP should create a draft letter that includes the member's representative. **MCO Response:** 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.		**Recommendation** The former letter template did not meet compliance with this requirement, but the new letter templates that were approved on March 3rd, 2020 should address this issue moving forward. The MCO should ensure the new template is used moving forward.	requirement.
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 PIHP 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	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy and is addressed by the most recently approved Appeal Written Notification letter templates. **File Review** One (1) of the 10 files met compliance with this requirement. Three (3) of the 10 cases were not applicable to this requirement. Six (6) of the 10 files reviewed did not	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			information on how to make this request. **MCO Response**: 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. **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.		meet this requirement. **Recommendation** The MCO should, in the appeals notice, inform the PIHP member that they have the right to request to receive benefits while a state fair is pending. It is acknowledged that letter templates were updated in March 2020, hence why compliance was not met for the six applicable appeals files.	
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.	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy and is addressed by the most recently approved Appeal Written Notification letter templates where a decision	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template.

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			Zero (0) of 7 appeals files reviewed were compliant. Seven (7) of 7 appeals files reviewed were not compliant. **Recommendation:** The PIHP 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. **MCO Response:** 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. **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,		is upheld. **File Review** One (1) of the 10 files met compliance with this requirement. Three (3) of the 10 cases were not applicable to this requirement. Six (6) of the 10 files reviewed did not meet this requirement. **Recommendation** The MCO should inform the PIHP member what costs they are responsible for if a decision is upheld. It is acknowledged that letter templates were updated in March 2020, hence why compliance was not met for the six applicable files.	Since that date, Magellan has maintained compliance for this requirement.

Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and Reviewer Instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.			

PAHP Final Audit Tools

Six 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.

Eligibility and Enrollment

Eligibility and Enrollment						
Contract Reference	**State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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			
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			
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	P/P for Eligibility and Enrollment Standard Operating Procedures	Full			

Eligibility and Enrollment						
Contract Reference	**State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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 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			
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 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	P/P for Eligibility and Enrollment Standard Operating Procedures	Full			

Eligibility and Enrollment						
Contract Reference	**State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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			
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			
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 compliance with 42 CFR §438.3(d).	P/P for Eligibility and Enrollment Standard Operating Procedures	Full			
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			

Eligibility and Enrollment						
Contract Reference	**State Contract Requirements (Federal Regulations 438.100, 438.102, 438.218, 438.226)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
10.1.6	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. **Recommendation:** The PIHP 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 PIHP indicated that the missing language will be added to future policy. MCO Response: 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.	Full	This requirement is addressed in the updated Discharge from CSoC Procedure, from the Discharge from CSoC Workflow Policy.	

Member Grievances and Appeals

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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.					

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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 respect to the Contractor's staff authorized to review and respond to appeals and require corrective action	P/P for Grievances and Appeals	Full			
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			
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.	P/P for Grievances and Appeals Communication with LDH if applicable	Full			

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	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 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			
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			
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			
11.3	**Notice of Adverse Benefit Determination**					
11.3.1	Language and Format Requirements	P/P for Notice of	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
11.3.1.1	.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.	Adverse Benefit Determination				
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: .9 The adverse benefit determination the Contractor intends to take; .10 The reasons for the adverse benefit 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.	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 were compliant. One (1) member did not receive a notice of adverse benefit determination. **Recommendation:** The PIHP should ensure all members who have had benefits denied receive a notice of adverse benefit determination. MCO Response: 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.	Substantial	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. Magellan indicated that new revised letter templates were created to satisfy recommendations from the prior year's audit, were approved by LDH on March 3rd, and put into use after March 4th, 2020. Letter templates prior to this date did not include new revised language. **File Review Results:** One (1) out of ten denial notification letters fully met the requirement. Nine (9) out of 10 clinical denial notification letters satisfied 7 of the 8 requirements because letters were sent to members prior to the revised letter format date of implementation and did not include item number 7 of the regulatory requirement on the letters. **Recommendation** The MCO should ensure that new letter templates, which were approved on March 3rd, 2020, will be used moving forward to meet compliance with this requirement.	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
					Nine (9) of the 10 letters reviewed were for cases prior to the new letter template implementation date hence why their letter templates did not address item 7 of this requirement.	
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			
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			
11.3.3.1.3 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	By the date of action for the following: 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,	P/P for Notice of Adverse Benefit Determination	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 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.					
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			
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 the extension is in the member's interest.	P/P for Notice of Adverse Benefit Determination Includes File Review	Full			
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	P/P for Notice of Adverse Benefit Determination	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member 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.	Includes File Review				
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			
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			
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	P/P for Notice of Adverse Benefit Determination	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	extension is in the member's interest.					
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			
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			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 11.3.6.1 11.3.6.2 11.3.6.3 11.3.6.4	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 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	P/P for Grievances and Appeals	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
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			
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			
11.4.1.1.3. 11.4.1.1.3.1	Ensure that the individuals who make decisions on grievances and appeals are individuals:	P/P for Grievances and Appeals	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual;	Includes File Review				
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. 3. A grievance or appeal that involves clinical issues.	P/P for Grievances and Appeals File Review	Full			
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			
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,	P/P for Grievances and Appeals	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 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 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			
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	P/P for Appeals File Review	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member of the limited time available in the cases of an expedited appeal.					
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 PIHP should ensure that all members who file an appeal and whose appeal is denied receive a notice of adverse benefit determination. MCO Response: 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.	Substantial	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. **File Review Results** Nine (9) out of ten appeals files met compliance with the requirement. One (1) out of 10 appeal letters did not meet compliance, and the plan acknowledges this was due to a copy and paste error from a case manager. **Recommendation** The MCO should place review processes in place to minimize process errors.	Quality control procedures were implemented to ensure integrity of the UM letter templates is maintained as evidenced by the following procedure, letter template, and training documents. Internal UM Quality Controls Procedure_Approved_09.16.2020 Magellan CSoC UM NOA Template_Quality Controls_10.01.2020.docx Magellan CSoC UM Letter Template Training
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 File Review	Substantial This requirement is addressed in the Medicaid: Adverse Benefit Determination Appeal, pages 4 to 5.	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy. **File Review Results**	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			File Review Results: Eight (8) of 10 appeals files were compliant. Two (2) of 10 appeals files reviewed were not compliant. **Recommendation :** For cases where a denial is overturned after an appeal, the PIHP should create a draft letter that includes the member's representative. MCO Response: 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.		One (1) of the ten appeals files met compliance and nine (9) out of the ten appeals did not meet compliance since they used older letter templates. **Recommendation** The former letter template did not meet compliance with this requirement, but the new letter templates that were approved on March 3rd, 2020 should address this issue moving forward. The MCO should ensure the new template is used moving forward.	this requirement.
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			
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			
11.4.5	Failure to Make a Timely Decision	P/P for Appeals	Full			

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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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
11.4.5.1 11.4.5.2	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					
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			
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			
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			
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			
11.4.8.3	Expedited Resolution of Appeals	P/P for Appeals	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
11.4.8.3.1	.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.	File Review				
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			
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			
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			
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			
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	P/P for Grievances and Appeals	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 expires.	File Review				
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			
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			
11.4.9.2	The denial of a request for expedited resolution of appeal does not constitute an adverse benefit determination or					

Member Grievances and Appeals						
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	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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, the member's request will be deemed to have exhausted the Contractor's process as per Section 11.4.8.4.3. above.	P/P for Appeals	Full			
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			
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			
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			
11.4.12.1.2	2. A description of how the member's behavioral healthcare	P/P for Notice of Resolution	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	needs will or have been met; and	File Review				
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 File Review	Full			
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			
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			
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			
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			
11.4.13.4.1.	The right to request a State Fair Hearing, and how to do so;		Full			
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.	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy and is addressed by the most recently approved Appeal Written Notification letter templates.	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 PIHP 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. MCO Response: 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. **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.		**File Review** One (1) of the 10 files met compliance with this requirement. Three (3) of the 10 cases were not applicable to this requirement. Six (6) of the 10 files reviewed did not meet this requirement. **Recommendation** The MCO should, in the appeals notice, inform the PIHP member that they have the right to request to receive benefits while a state fair is pending. It is acknowledged that letter templates were updated in March 2020, hence why compliance was not met for the six applicable appeals files.	
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.	Minimal	This requirement is addressed in the Medicaid Adverse Benefit Determination Policy and is addressed by the most recently approved Appeal Written Notification letter templates where a decision is upheld.	The non-compliant files contained the letter template used on or before 03/04/2020, which is the date that the LDH approved the attached template. Since that date, Magellan has maintained compliance for this requirement.

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Zero (0) of 7 appeals files reviewed were compliant. Seven (7) of 7 appeals files reviewed were not compliant. **Recommendation:** The PIHP 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. MCO Response: 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. **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, PIHP's, or PAHP's adverse benefit determination.		**File Review** One (1) of the 10 files met compliance with this requirement. Three (3) of the 10 cases were not applicable to this requirement. Six (6) of the 10 files reviewed did not meet this requirement. **Recommendation** The MCO should inform the PIHP member what costs they are responsible for if a decision is upheld. It is acknowledged that letter templates were updated in March 2020, hence why compliance was not met for the six applicable files.	

Member Grievances and Appeals						
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	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
11.4.14	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 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			
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	P/P for request of	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate.	State Fair Hearing				
11.5	**Prohibition Against Punitive Action**					
11.5.1	The Contractor shall not take punitive 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.	P/P for Appeals	Full			
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	P/P for Grievance and Appeals P/P for Continuation of Benefits	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 The member timely files for continuation of benefits.					
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 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.	P/P for Grievance and Appeals P/P for Continuation of Benefits P/P for Reinstated Benefits	Full			
11.6.3.2	A provider may not request continuation of benefits for the member.	P/P for Continuation of Benefits Provider Handbook	Full			
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	P/P for Grievance and Appeals P/P for Continuation of Benefits	Full			

Member Grievances and Appeals						
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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	because of the requirements of this section, and in accordance with the policy set forth in 42 CFR §431.230(b).					
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. 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.	P/P for Grievance and Appeals P/P for Continuation of Benefits	Full			
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			
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	P/P for Grievance and Appeals	Full			

Member Grievances and Appeals						
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	Prior Review Results	Review Determination	Comments (Note: For any element 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 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.					
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			
11.7.2.1	General description of the reason for the appeal or grievance;	P/P for Grievance and Appeals	Full			
11.7.2.2	Date the request was received;	P/P for Grievance and Appeals	Full			
11.7.2.3	Date of each review, and if applicable, date of each review meeting;	P/P for Grievance and Appeals	Full			
11.7.2.4	Resolution of each appeal or grievance, if applicable;	P/P for Grievance and Appeals	Full			
11.7.2.5	Date of resolution at each level, if applicable;	P/P for Grievance and Appeals	Full			
11.7.2.6	Member name and Medicaid number;	P/P for Grievance and Appeals	Full			
11.7.2.7	Summary of grievances and appeals;	P/P for Grievance	Full			

Member Grievances and Appeals						
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	Prior Review Results	Review Determination	Comments (Note: For any element 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 Appeals				
11.7.2.8	Current status;	P/P for Grievance and Appeals	Full			
11.7.2.9	Resolution with date of resolution and resulting corrective action;	P/P for Grievance and Appeals	Full			
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			
11.7.2.11	The status and resolution of all claims disputes;	P/P for Grievance and Appeals	Full			
11.7.2.12	Trends and types of grievances and appeals;	P/P for Grievance and Appeals	Full			
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			
11.7.2.14	The number of State Fair Hearings and resolution during the reporting period.	P/P for Grievance and Appeals	Full			
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			
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			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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			
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			
6.1.2.2	The Contractor shall also be required to	Network Provider Development	Substantial	Substantial	This requirement is	Magellan remains

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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).	and Management Plan P/P for Provider Network	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). 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.		addressed in the CSoC unit-Quality Improvement –Clinical Management Program Evaluation (page 174). Barriers identified, interventions, and recommendations for 2020 were clearly laid out. A major intervention was the increase in reimbursement rates for LMHPs, prescribers, and Short Tem Respite providers which went into effect in July 2019. **<u>Recommendation</u>** The MCO should continue efforts to monitor the interventions put into place in the latter part of 2019. These include continued engagement of Wraparound Agencies in training and technical support for staff implementation of the workbook project to improve quality of services provided by non-licensed individuals, and continued monitoring the impact of increased reimbursement rates.	committed to members having 100% desired access to all types of providers and services. We will continue evaluating member needs through satisfaction surveys, geographical data, and service utilization. Although the workbook project was delayed due to the recent pandemic, efforts have begun to distribute the workbooks to providers and a refresher presentation on the utilization the tools is scheduled for November 2020. Provider and service needs remain as agenda items for the monthly meetings between Magellan, LDH and the Wraparound Agencies. All growth and services needs will continue to be monitored and reported to the Network Strategy Committee.

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.1.3	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			
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			
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			
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			
6.1.7 6.1.7.1 6.1.7.2 6.1.7.3	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	Network Provider Development and Management Plan P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.1.7.4 6.1.7.5	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.	File Review				
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 requirements pertaining to Freedom of Choice (FOC).	P/P for Provider Network	Full			
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			
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	P/P for Provider Network P/P for Access and Availability	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 this contract are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary.					
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			
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	P/P for Provider Network P/P for Provider Credentialing/ Re-Credentialing P/P for Provider Complaints	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	unresolved; however, the issue must be resolved within ninety (90) calendar days.					
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			
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			
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 PIHP 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	Full	This requirement was addressed in Provider Credentialing Process-Update Approved 12/19.	

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			acute populations based on the expectations of the contractor and LDH. <u>MCO Response:</u> 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:					
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			
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			
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	P/P for provider selection P/P for anti-discrimination	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	designed to maintain quality of services and control costs and is consistent with its responsibilities to members.					
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. <u>MCO Response:</u> Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.	Full	This requirement was addressed in the Provider Credentialing Process-Update Approved 12/19.	
6.1.18	The Contractor shall at least semi-annually validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted network providers.	P/P for demographic data validation	Full			
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	P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
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			
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. <u>MCO Response:</u> Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.	Full	This requirement was addressed in the Provider Credentialing Process-Update Approved 12/19.	
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	P/P for provider network shortage	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	available to meet that particular need.					
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 standard in a policy. On-site, Magellan indicated that they would incorporate the standard in a policy. <u>MCO Response:</u> Magellan's revised Credentialing Process will be submitted to the LDH for approval by 8/31/19.	Full	This requirement was addressed in the Provider Credentialing Process-Update Approved 12/19.	
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			
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	Example of LDH communication if applicable	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
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			
6.2.3.1 6.2.3.1.1 6.2.3.1.2 6.2.3.1.3 6.2.3.1.4 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	In establishing and maintaining the network, the Contractor shall consider and report on the following: 1 CSoC enrollment. 2 Utilization of services, taking into 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	Provider Network Development and Management Plan Reports on these measures GeoAccess Report P/P for utilizing out-of-network providers	Full			

Provider Network Requirements						
Contract Reference	State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	behavioral health 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 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	The Network Development and Management	Provider Network Development	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.2.4.1	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.	and Management Plan				
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			
6.2.4.2.3 6.2.4.2.3.1 6.2.4.2.3.2 6.2.4.2.3.3	Growth trends in eligibility and enrollment, including 1 Barriers to sufficiently addressing unmet 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.	Provider Network Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.2.4.3 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			
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			
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. The Network Development Plan captures the number of providers that provide sign language services, but there is no evidence	Full	This requirement was addressed in the LA CSoC QI QM Program Evaluation 2019 04 17 2020, pages 13-16, and Face to Face Interpretation CSoC Usage 4.2019 3.2020.	

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			that members' sign language needs are assessed and whether the number of providers who provide sign language services is sufficient. **Recommendation:** The PIHP 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. MCO Response: IPRO's recommendation will be included in the Annual Network Development Plan for the 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			
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			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.2.4.5.2.2	Assessing the cultural competence of the providers on an ongoing basis, at least annually.	Provider Network Development and Management Plan	Full			
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			
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			
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			
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	Provider Network Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	entity's goods or services as well as with that person's parent, caregiver, custodian, spouse, or companion, in appropriate circumstances.					
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			
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			
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			
6.2.4.6.3	Develops and expands the use of evidence-based models to deliver covered services	Provider Network Development and Management Plan	Full			
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			
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			
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			
6.2.4.6.7	Improves and increases services available for individuals with behavioral health and	Provider Network Development and Management Plan	Substantial This requirement is partially addressed in	Full	This requirement was addressed in the LA CSoC	

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	developmental disabilities, including autism spectrum disorders, which incorporates reducing health disparities and includes long-range fiscal planning to promote training and fiscal sustainability.		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. **Recommendation:** The PIHP 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. MCO Response: This standard will be assessed and reported in Magellan's Network Development Plan for the upcoming contract year.		QI QM Program Evaluation 2019 04 17 2020, pages 17-19 and 185.	
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			
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			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.2.4.6.8.2	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 PIHP should add this element to their provider monitoring tool. MCO Response: 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.	Full	This requirement was addressed in the LA CSoC QI QM Program Evaluation 2029 04 17 2020, pages 45-46.	
6.2.4.6.8.3	Are access to care standards being met by these providers?	Provider Network Development and Management Plan	Full			
6.2.4.7	Maintain minimum standards for certified peer and family support as set by LDH.	Provider Network Development and Management Plan	Full			
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			
6.2.4.9	A process for expedited and temporary credentials for out of network providers.	Provider Network Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Recruit, select, credential, re-credential and contract with providers in a manner that incorporates quality management, utilization, administrative and onsite audits and provider profiling.					
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			
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			
6.2.6	Contractor Network Development and Management policies shall be subject to approval by LDH.		Full			
6.3	**Network Standards and Guidelines**					
6.3.1	Access Standards	P/P for access to services	Full			

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.3.1.1	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 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	Full	This requirement is addressed in the LA CSoC QI QM Program Evaluation 2019 04 17 2020, pages 36-41, Quarterly Reports.	

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			working to improve access to specialists where the standard is not met. **Recommendation:** The PIHP 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). MCO Response: 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). Psychologists – standard not met. Advanced practiced registered nurses – standard not met. LCSWs – standard not met. Psychiatrists – standard was met. **Recommendation:** The PIHP should revise the footnote in the	Full	This requirement is addressed in the LA CSoC QI QM Program Evaluation 2019 04 17 2020, pages 36-41, Quarterly Reports.	

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Geo Access Report to state the access standard according to the contract (30 miles or 60 minutes for 100% of the members). MCO Response: The Geo Access Report template has been updated 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 PIHP should revise the footnote in the Geo Access Report to state the access standard according to the contract requirements. MCO Response: The Geo Access Report template has been updated to reflect the current standards.	Full	This requirement is addressed in the LA CSoC QI QM Program Evaluation 2019 04 17 2020, pages 36-41, Quarterly Reports.	
6.3.1.1.2	The Contractor shall report on service accessibility 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.		Full			
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			
6.3.1.1.4	There shall be no penalty if the member					

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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. The evidence did not address the requirement to include the appointment standards in the member handbook.	Full	This requirement is addressed in the LA CSoC Member Handbook, pages 7-8.	
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:					

Provider Network Requirements						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.3.1.2.2.1	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			
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			
6.3.1.2.2.3	Routine, non-urgent behavioral healthcare shall be available with an appointment within fourteen (14) days of referral.		Full			
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 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).					

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	Prior Review Results	Review Determination	Comments (Note: For any element 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 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	The Contractor shall include in all materials the following: 1. The date of issue;					

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.1.11.2 5.1.11.3	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, 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			
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	P/P for Member Education Materials Example of written education materials Example of LDH approval	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	approved by DOA/OSP.					
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			
5.5.3	The Contractor shall not begin member education activities prior to approval by LDH.	P/P for Member Education Materials	Full			
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 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	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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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. 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			
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; 5. McLaughlin SMOG Index; or 6. Other computer generated readability indices accepted by LDH.	P/P for Written Member Materials Guidelines Member Handbook Evidence that written materials have been tested against the reading level standard	Full			
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			
5.6.1.4	All written member materials must notify the member that real-time	P/P for Written Member Materials	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	oral interpretation is available for any language at no expense to them, and how to access those services.	Guidelines Example of written member materials				
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. **<u>Recommendations</u>** The PIHP 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	Full	This requirement is addressed in the Non-Discrimination and Access Policy-Approved 12/19, as well as via 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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			member. MCO Response: 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.			
5.6.1.6	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			
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			
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			
5.7.1.3	The Contractor website should, at a minimum, be in compliance with	P/P for Written Member Materials	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.	Guidelines Demonstration of machine readability				
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			
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			
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 impact the public, such as natural and human-caused disasters that would require time	P/P for Written Member Materials Guidelines Review of website	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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			
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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.8.2.2	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			
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		Note: As of 4/21/2020, the requirement that the welcome letter and member handbook be distributed face-to-face has been temporarily waived. The State recommends mailing or emailing the letter and handbook to the member/members family.	
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: 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. 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	P/P for distribution of written member materials	Substantial This requirement is addressed in the Member Education Plan Narrative. The PIHP does not have evidence of such educational materials as brochures, posters, calendars, or EDSTD Outreach materials. Member Services handles members who access the	Full	Note: As of 4/21/2020, the requirement that the welcome letter and member handbook be distributed face-to-face has been temporarily waived. The State recommends mailing or emailing the letter and handbook to the member/members family. This requirement is fully addressed via review of the Quarterly Online	

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	established by LDH for these materials and/or programs.		system inappropriately. **<u>Recommendations</u>** The PIHP 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 PIHP should consider adding a calendar to the website, including reminders for routine services (e.g., flu shots, vaccinations, EPSTD services). The PIHP 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. <u>MCO Response:</u>		Newsletters	

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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'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), and 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			
5.9.2.1	Table of contents;	Member Handbook	Full			
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			
5.9.2.3	CSoC eligibility requirements;	Member Handbook	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.9.2.4	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			
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			
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			
5.9.2.7	Member's Bill of Rights	Member Handbook P/P for Members' Bill of Rights	Full			
5.9.2.8	Information regarding the member call center;	Member Handbook Example of materials informing members of the member call center	Full			
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			
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			
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			
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			
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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.9.2.14 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			
5.9.2.15	The post-stabilization care services rules set forth in 42 CFR §422.113(c);	Member Handbook	Full			
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			
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			
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			
5.9.2.18.5 5.9.2.18.5.1	The fact that, when requested by the member: 1. Benefits will continue if the member files an appeal or a request for	Member Handbook P/P for continuation of member	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.9.2.18.5.2 5.9.2.18.5.3	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 has final authority to determine whether services must be provided as per LAC 50:I.3717.C.	benefits P/P for State Fair Hearings				
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			
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			
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			
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			
5.9.2.22	Family's/caregiver's or legal guardian's role in the assessment,	Member Handbook	Full			

Member Services						
Contract Reference	State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;					
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			
5.9.2.24	Information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;	Member Handbook	Full			
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			
5.9.2.26	How to identify and contact the WAAs and FSO;	Member Handbook	Full			
5.9.2.27	How to obtain emergency and non-emergency medical transportation;	Member Handbook	Full			
5.9.2.28	Information about Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services;	Member Handbook	Full			
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 with Section 5.15. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;	Member Handbook	Full			
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			
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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.9.2.32	Any additional text provided to the Contractor by LDH or deemed essential by the Contractor;	Member Handbook	Full			
5.9.2.33	The date of the last revision;	Member Handbook	Full			
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			
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			
5.9.3	The Contractor shall review the member handbook at least annually by contract year. If the 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.	Distribution information	Full			
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			
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			
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,	P/P for updates to Provider Directory	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
5.10.4 5.10.4.1 5.10.4.2 5.10.4.3 5.10.4.4 5.10.4.5 5.10.4.6	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 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.	P/P for Provider Directory Provider Directory documents	Full			
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 grievances. The call center staff determines the reason for the call and transfers 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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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			
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			
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			
5.11.5	The member line shall be answered by a live voice at all times.	P/P for answering of member line	Full			
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			
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.					

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.11.8	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			
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 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.	P/P for help line addressing staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards Example of LDH communication if applicable Example of synopsis	Full			
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			
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			
5.11.17	The Contractor's call abandonment rate shall not exceed five percent (5%) monthly.	Call Center Metrics report	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.11.18	The call center shall utilize a language line translation system for callers whose primary language is not English. Assistance should include, 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.	P/P for language translation	Full			
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			
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			
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			
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			
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			
5.12.1.2	Transfer calls to other telephone lines;	P/P for call transfers	Full			
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			
5.12.1.4	Provide a message that notifies callers that the call may be monitored for quality control purposes;	ACD script	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.12.1.5	Measure the number of calls in the queue at all times, particularly peak times;	Call Center Metrics	Full			
5.12.1.6	Measure the length of time callers are on hold;	Call Center Metrics	Full			
5.12.1.7	Measure the total number of calls and average calls handled per day/week/month;	Call Center Metrics	Full			
5.12.1.8	Measure the average hours of use per day;	Call Center Metrics	Full			
5.12.1.9	Assess the busiest times and days by number of calls;	Call Center Metrics	Full			
5.12.1.10	Record calls to assess whether answered accurately;	Call Center Metrics	Full			
5.12.1.11	Measure and report average speed to answer;	Call Center Metrics	Full			
5.12.1.12	Establish separate call tracking and record keeping for tracking and monitoring provider and member phone lines;	Call Center Metrics	Full			
5.12.1.13	Track and report on nature of calls;	Call Center Metrics	Full			
5.12.1.14	Track and monitor call abandonment rates, which shall not exceed five percent (5%) monthly.	Call Center Metrics	Full			
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			
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			
5.12.1.17	Inform the member to dial 911 if there is an emergency.	ACD script	Full			
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	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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	higher than a fifth grade level, or as determined appropriate by LDH. The minimum written information shall address 42 CFR §438.100 and include:					
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			
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			
5.13.1.1.3	The right to be treated with respect and with due consideration for his or her dignity and privacy;	P/P for HIPAA Compliance Members' Bill of Rights	Full			
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			
5.13.1.1.5	The right to receive rehabilitative services in a community or home setting.	Members' Bill of Rights	Full			
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			
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			
5.13.1.1.8	The right to appeal or express a concern about the Contractor,	Members' Bill of Rights	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 the care it authorizes, and receive a response in a reasonable period of time.					
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			
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			
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			
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			
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			
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			
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			
5.13.1.1.16	The right to be treated with dignity and respect by a professional, competent, and ethical work force in the least restrictive manner as possible.	Members' Bill of Rights	Full			
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			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.13.1.1.18	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			
5.13.1.1.19	The right to engage in appropriate leisure, recreational, and other activities.	Members' Bill of Rights	Full			
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			
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			
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			
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			
5.13.1.1.24	The right to be informed of the aforementioned rights both orally and in writing upon admission and upon request.	Members' Bill of Rights	Full			
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	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;	Member Handbook	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
5.13.2.3.3 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	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 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			
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	P/P for notification of provider termination or change Example of this communication if	Full			

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.	applicable				
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 notice of a provider's termination to each member who received care from or was seen on a regular basis by the provider.	P/P for notification of provider termination or change Example of this communication if applicable	Full			
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			
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,	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 PIHP's translation and interpreter services.	Full	This requirement is addressed in the Non-discrimination and Language Access Policy—approved 12/19.	

Member Services						
Contract Reference	**State Contract Requirements (Federal Regulation 438.100, 438.102, 438.210, 438.218, 438.224)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	materials 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.		This policy does not explicitly address the 5% requirement, or the 90-day requirement. **Recommendation:** The PIHP should update the Non-discrimination and Language Access Policy to include the language required in the standard. MCO Response: Magellan's Nondiscrimination and Language Access policy has been updated to include this information.			

Quality Management

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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			
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			
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			
12.1.1.4	Collect data on race, ethnicity, primary language, gender, age, and geography (e.g., urban/rural).	P/P for QAPI	Full			
12.1.1.5	Identify and address health disparities between population groups, such as but not limited to quality of care, access to care and health outcomes.	P/P for QAPI	Full			
12.1.2	Detect and address under-and-over utilization of services.	P/P for QAPI	Full			
12.1.2.1	Verify members' receipt of services.	P/P for QAPI	Full			
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.	P/P for QAPI P/P for site visits	Full			

Quality Management						
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	Site visits shall be conducted according to a periodic schedule determined by the Contractor and approved by LDH.					
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			
12.1.2.6	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			
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			
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			
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			
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			
12.1.2.11	Participate in the LDH quality committee meetings and other meetings as directed by LDH.	LDH Quality Committee meeting agendas, minutes, and sign-in sheets	Not applicable as per LDH			
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	The Contractor shall form a QAPI committee that shall, at a minimum	P/P for QAPI	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.2.1.1 12.2.1.2	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.	Committee Organizational Chart				
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 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. .	P/P for QAPI Committee	Full			
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			
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	P/P for QAPI work plan	Full			

Quality Management						
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	responsibilities.					
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			
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			
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			
12.2.3.2.5	Describe how the Contractor will obtain feedback from providers and members.	P/P for QAPI work plan	Full			
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. **<u>Recommendations:</u>** The PIHP 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	Full	This requirement is addressed in Quality Improvement-Clinical Management Program Evaluation-11/01/18-12/31/19	

Quality Management						
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			assessed for accuracy. <u>MCO Response:</u> 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			
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			
12.2.3.3.2.	Include metrics and associated benchmarks for the wraparound agency scorecard.	P/P for QAPI work plan	Full			
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	P/P for QAPI work plan	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	validation methods.					
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			
12.2.3.4 12.2.3.4.1 12.2.3.4.2	The QAPI committee shall submit an annual QAPI 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;	Not applicable as per LDH				
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			
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			
12.4.1.2	The Contractor shall ensure provider and member enrollment staff receive training and are knowledgeable about the home and community-	P/P for HCB Waiver Services	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	based setting rule, including the settings that are 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.					
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			
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 the1915c 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			
12.4.1.5	The Contractor shall monitor members on no less 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.	P/P for HCB Waiver Services	Full			
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	P/P for HCB Waiver Services Evidence of LDH notification if	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	be non-compliant with the setting rule and proposed action steps to address non-compliance.	applicable				
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			
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			
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			
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			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.4.3.2	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			
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			
12.4.3.4	The Contractor shall collect data from the WAAs 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.)	P/P for data collection from WAAs	Full			
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			
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			
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			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.4.3.8	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 in quality measurements required by LDH.	P/P for Quantitative reports	Full			
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			
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			
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			
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			
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			
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			
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			
12.5.4.4 12.5.4.4.1	The Contractor shall submit PIP outcomes annually to LDH, using a format approved by LDH, including but not limited to:	P/P for PIPs Evidence of timely	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.5.4.4.2 12.5.4.4.3 12.5.4.4.4	.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.	submission				
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 7. Inter-rater reliability methods.	P/P for provider monitoring	Full			
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			
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	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;	P/P for provider monitoring	Full			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.6.3.9 12.6.3.10 12.6.3.11	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.					
12.6.4	The Contractor shall ensure that an appropriate corrective action is taken when a provider or their 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.	P/P for provider monitoring P/P for CAPs	Full			
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			
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			
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			

Quality Management						
Contract Reference	**State Contract Requirements (Federal Regulations 438.206, 438.207, 438.208, 438.114)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.8	**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. .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.	P/P for Quality Reviews	Full			
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			
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			

Program Integrity

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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			
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 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	P/P for PI P/P for Fraud, Waste, And Abuse Example of provider/subcontractor agreements containing required language	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 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			
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			
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 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	P/P for Fraud, Waste, and Abuse P/P for external audits	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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 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	P/P for Fraud, Waste, and Abuse	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
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 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.	P/P for Fraud, Waste, and Abuse	Full			
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			
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	P/P for employee training Training Materials Sign-in sheets	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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; 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 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: 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.	P/P for Fraud, Waste, and Abuse	Substantial This requirement is addressed in PI 145 report. Missing from documentation are the requirements that: 1. Contract the subject … 2. Enter into or attempt … 3. Accept any monetary … " **Recommendation:** The PIHP should include discussion of the	Full	This requirement is addressed by the Special Investigations Unit Standard Operating Procedure document on page 2.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 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 … " <u>MCO Response:</u> 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 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.	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan	Full			
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	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.					
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			
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			
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			
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			
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			
13.1.2.3.5	A description of the methodology and standard operating	P/P for Fraud, Waste, and	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;	Abuse Fraud, Waste, and Abuse Compliance Plan				
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			
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			
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			
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			
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			
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			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.1.2.4	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 PIHP should develop policies and a standardized procedure for referral of suspected Fraud, Waste, and Abuse to LDH. MCO Response: 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.	Full	This requirement is addressed by the Medicaid Program Integrity and Compliance Program on page 29.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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			
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			
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			
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			
13.1.2.11	Description of effective training and education for 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;	P/P for Fraud, Waste, and Abuse Fraud, Waste, and Abuse Compliance Plan Training material	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.1.2.12	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			
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			
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	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.	Full	This requirement is addressed by the Medicaid Program Integrity and Compliance Program on page 29.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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.		**Recommendation:** The PIHP should incorporate contractual requirement to report ownership interest to LDH within 30 days into policy. MCO Response: 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 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/ ;	P/P for background screening	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 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 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			
13.2.3 13.2.3.1 13.2.3.2 13.2.3.3 13.2.3.4	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;	P/P for background screening	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.2.3.5	.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.					
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. §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.	Evidence of timely notification if applicable	Not applicable			
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			
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			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.3.3	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.	Not Applicable	This did not occur during the review period.	
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			
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 PIHP should include in policy that the contractor is responsible for the return to the state of any payments	Full	This requirement is addressed by the Medicaid Program Integrity and Compliance Program on page 29.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			made for services rendered by an excluded provider. <u>MCO Response:</u> 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			
13.4.4	Exclusion from the Medicaid program; .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.	P/P for contracting requirements	Full			
13.5	**Program Integrity Reporting and Investigating Suspected Fraud and Abuse**					

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.5.1	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 PIHP should include in policy which agencies and the time frame, for reporting suspected fraud, waste, and abuse. MCO Response: Magellan's Program Integrity & Compliance Program policy will be updated to reflect IPRO's recommendation by 8/31/19.	Full	This requirement is addressed by the Medicaid Program Integrity and Compliance Program on page 26 to 28.	
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. These reportable actions will include denial of credentials, enrollment, or contracts. Additionally, when the	P/P for Fraud, Waste, and Abuse Evidence of timely reporting if applicable	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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			
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			
13.5.3.2	Number of complaints reported to the Compliance Officer; and	P/P for Fraud, Waste, and Abuse	Full			
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 complainant.	P/P for Investigations	Full			
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	Evidence of timely reporting	Not applicable Did not occur during review period.	Not Applicable	This requirement is addressed by the Medicaid Program Integrity and Compliance Program on page 29. However there are no cases to report.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	effective date of the exclusion as per 42 CFR §455.17.					
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			
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			
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: .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 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.	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:** The PIHP should include subsections .1, .2, and .3 in policy documents. MCO Response: Magellan's Administration of Claims Overpayment Recovery policy will be updated to reflect IPRO's	Full	This requirement is addressed in the SIU-10 Louisiana CSOC Regulatory Contractual Requirement on page 4.	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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 by 8/31/19.			
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			
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			
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 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.	Evidence of timely notification	Full			
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			
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			
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	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Evidence of timely notification if applicable				
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			
13.5.16	The Contractor shall be subject to a civil penalty, to be imposed by LDH, for willful failure to report fraud and abuse by employees, subcontractors, recipients, enrollees, applicants, or providers to LDH or to MFCU, as appropriate.	P/P for Fraud, Waste, and Abuse	Full			
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			
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			
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			
13.5.20	The State shall not transfer its law enforcement functions to					

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element 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.					
13.6	**Right to Review and Recovery by Contractor and LDH**					
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			
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			
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.	Full	This requirement is addressed in the SIU-10 Louisiana CSOC Regulatory Contractual Requirement on page 5.	
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 amount paid. LDH shall respond within ten business days to each review notification. In the event LDH	Evidence of communication if applicable	Not applicable Did not occur during the review period.	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**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	does not 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 PIHP should include in policy the requirement that contact with a provider shall be prohibited in instances resulting from suspected fraud. MCO Response: Magellan's Program Integrity and Compliance policy will be updated to reflect IPRO's recommendation by 8/31/19.	Full	This requirement is addressed in the SIU-10 Louisiana CSOC Regulatory Contractual Requirement on page 6.	
13.6.6	If the Contractor fails to collect at least a portion of an identified recovery after three hundred and sixty-five (365)					

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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 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.	Evidence of timely notification if applicable	Not applicable Did not occur during the review period.	Not applicable	Did not occur during the review period.	
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.	Full	This requirement is addressed in the SIU-10 Louisiana CSOC Regulatory Contractual Requirement on page 6. The plan provided two request for information (RFI) examples, where the requestor, Medicaid Fraud Control Unit (MFCU), asked for documentation on select providers. One request was made on 1/22/2020 for Rehab services of Arcadiana and the plan provided email documentation for the	

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
					provider by 2/7/2020. The other example provided was an MFCU request for records on Washington Street Hope Center on Aug. 7th, 2019. The plan provided a response by Aug. 22, 2019 that there were no investigations for the requested provider. Both cases exceed the 14 day turnaround by a day or two, but the plan provided a memorandum from MCFU dated Sept. 2018, that the plan can provide documentation within a 30 day timeframe and if more time is needed, the plan must inform LDH and MFCU of an anticipated date of providing information. The plan meets compliance with this requirement.	
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	P/P for overpayment procedures	Full			

Program Integrity						
Contract Reference	**State Contract Requirements (Federal Regulation 438.602, 438.608, 438.610)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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. 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			