LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review Compliance Review

for

Louisiana Healthcare Connections

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the compliance review, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).[1-1]

Description of the External Quality Review Compliance Review

LDH requires its managed care entities (MCEs) to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. The 2023 compliance review, which comprises the calendar year (CY) 2022 review period (January 1, 2022−December 31, 2022), is the second year of the three-year cycle of compliance reviews. The compliance review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. The compliance reviews for the Louisiana Medicaid managed care program consist of 14 program areas referred to as "standards." LDH requested that HSAG conduct a compliance review of all standards not yet reviewed during the three-year compliance review cycle for each MCO, PAHP, and PIHP. Table 1-1 outlines the division of standards reviewed in Year One (CY 2021) and Year Two (CY 2022).

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Aug 1, 2023.

Table 1-1—Compliance Review Standards

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment	§438.56				✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓			
Standard III—Member Information	§438.10	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓			
Standard VIII—Provider Selection	§438.214	✓	✓	✓			
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓	
Standard X—Practice Guidelines	§438.236	✓	✓	✓			
Standard XI—Health Information Systems	§438.242	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓			
Standard XIV—Program Integrity	§438.608	✓	✓	✓			

[1] The compliance review standards comprise a review of all requirements, known as "elements," under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

Summary of Findings

Table 1-2 and Table 1-3 present an overview of the results of the 2023 compliance review for **Louisiana Healthcare Connections** (**LHCC**). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-2—Summary of Scores for the CY 2022 Compliance With Standards Review

Standard #	Standard Name	Total Elements	Number of Elements		Total Compliance Score
			M	*NM*	
I	Enrollment and Disenrollment	7	6	1	85.7%
	Total Compliance Score	**7**	**6**	**1**	**85.7%**

M=*Met*, ***NM***=*Not Met*

Total Elements: The total number of elements in each standard. This represents the denominator.

Total Compliance Score: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

Table 1-3—Summary of Scores for the CAP From the CY 2021 Review

	Total Elements in CAP	Number of Elements		Total Compliance Score From CAP
		M	*NM*	
Follow-Up on Corrective Action Plans (CAPs) From Prior Compliance Review	24	22	2	91.7%

M=*Met*, ***NM***=*Not Met*

Total Elements in CAP: The total number of elements within the CAP from the CY 2021 review. This represents the denominator.

Total Compliance Score From CAP: The overall percentages of the number of elements that received a score of *Met* (1 point) then dividing this total by the total number of elements.

LHCC received a score of 85.7 percent for Standard I—Enrollment and Disenrollment, which identified **LHCC** has opportunities for improvement. Appendix A documents strengths and opportunities for improvement. Appendix B documents detailed findings, including recommendations for program enhancements.

LHCC achieved compliance in 22 of 24 elements from the LDH-approved 2022 compliance review CAPs. **LHCC** must implement the remaining approved CAPs for the two elements for which compliance was not achieved. Appendix B documents detailed findings of the review of the implementation of the **LHCC**-approved 2022 compliance review CAPs.

Corrective Action Process

For any elements HSAG scored *Not Met*, **LHCC** is required to submit a CAP to bring the element into compliance with the applicable standard(s). The process for submitting the CAP is described in Section 3.

2. Methodology

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with LDH, performed compliance reviews of the five MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

The 2023 compliance review is the second year of the three-year cycle. The compliance review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific requirements. LDH requested that HSAG conduct a compliance review of all standards not yet reviewed during the three-year compliance review cycle for each MCO, PIHP, and PAHP. Table 2-1 outlines the division of standards reviewed in Year One and Year Two.

Table 2-1—Compliance Review Standards

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard I—Enrollment and Disenrollment	§438.56				✓	✓	✓
Standard II—Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓			
Standard III—Member Information	§438.10	✓	✓	✓			
Standard IV—Emergency and Poststabilization Services	§438.114	✓	NA				✓
Standard V—Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓			
Standard VI—Coordination and Continuity of Care	§438.208	✓	✓	✓			
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓			
Standard VIII—Provider Selection	§438.214	✓	✓	✓			

Standard	Associated Federal Citation[1]	Year One (CY 2021)			Year Two (CY 2022)		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓	
Standard X—Practice Guidelines	§438.236	✓	✓	✓			
Standard XI—Health Information Systems	§438.242	✓	✓	✓			
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓			
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓			
Standard XIV—Program Integrity	§438.608	✓	✓	✓			

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

This report presents the results of the 2023 compliance review, review period CY 2022 (January 1, 2022–December 31, 2022). LDH and the individual MCEs use the information and findings from the compliance reviews to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as "compliance review tools," to document the review. The content in the tools was selected based on applicable federal and State regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs' compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG's desk review consisted of the following activities.

Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCE a detailed timeline, description of the compliance review process, pre-virtual review information packet, and a post-virtual review document tracker.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for delegation file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an information system (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the compliance review tool, as described in the Data Aggregation and Analysis section.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.

- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for delegation.
- Member and provider materials.

HSAG obtained additional information for the compliance review through interactions, discussions, and interviews with the MCE's key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table 2-2—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during and after the site review	January 1, 2022–December 31, 2022
Information obtained through interviews	October 12, 2023
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Louisiana Medicaid managed care program at any time between January 1, 2022–December 31, 2022

3. Corrective Action Plan Process

LHCC is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for **LHCC** to use in preparing its plans of action to remediate any deficiencies identified during the 2023 compliance review. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring **LHCC** into full compliance with the deficient requirements. **LHCC** must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). **LHCC**'s CAP must be submitted to the HSAG SAFE site **no later than 30 calendar days after receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that **LHCC** will implement to bring the element into compliance.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring **LHCC** into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. Implementation of the CAP may begin once approval is received. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by **LHCC** in its submitted CAP.

Appendix A. Conclusions and Recommendations

Standard I—Enrollment and Disenrollment

Strengths Related to Quality	
+	The MCO does not request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, or diminished mental capacity.

Strengths Related to Access and Timeliness	
+	The MCO implemented documented processes that focus on ensuring members are not disenrolled for any reason other than those stated in the LDH contract.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The MCO's redline version of the Eligibility Guidelines policy, dated October 16, 2023, stated that the plan shall not discriminate against individuals enrolled, or use any policy or practice that has the effect of discriminating against individuals, based on their health history; health status; need for healthcare services or adverse change in health status; or on the basis of age, religious belief, sex/gender, sexual orientation, gender identity, disability, race, color, or national origin. The policy originally submitted for review did not reference race, color, national origin, or disability. The original policy also referenced potential members but did not include enrolled individuals. **Recommendations:** The MCO's revised policy submitted after the virtual review is acceptable for the CAP for this element. The MCO must submit the finalized and implemented policy once approved.

Appendix B. 2023 Compliance With Standards Review Tool

This appendix includes the completed review tool that HSAG used to evaluate **LHCC**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring **LHCC**'s performance into full compliance.

CY 2022 Compliance With Standards Review

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO agrees to accept individuals enrolled into its MCO in the order in which they apply without restriction (unless authorized by the Department). *42 CFR §438.3(d)(1)* 2022 Contract Citations: 11.9.1 2023 Contract Citations: 2.3.12.1; 2.3.12.1.1; 2.3.12.1.2	• LA.ELIG.01_-_Eligibility_Guidelines.pdf pg. 9	☒ Met ☐ Not Met
2. The MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. *42 CFR §438.3(d)(3-4)* 2022 Contract Citations: 11.10.1.3 2023 Contract Citations: 2.3.12.1; 2.3.12.1.3	• LA.ELIG.01_-_Eligibility_Guidelines.pdf pg. 9 **Virtual Review Follow-Up Document Submission** • LA.ELIG.01_-_Eligibility_Guidelines_.pdf pg. 1	☐ Met ☒ Not Met
HSAG Findings: The MCO's redline version of the Eligibility Guidelines policy, dated October 16, 2023, stated that the plan shall not discriminate against individuals enrolled, or use any policy or practice that has the effect of discriminating against individuals, based on their health history; health status; need for healthcare services or adverse change in health status; or on the basis of age, religious belief, sex/gender, sexual orientation, gender identity, disability, race, color, or national origin. The policy originally submitted for review did not reference race, color, national origin, or disability. The original policy also referenced potential members but did not include enrolled individuals.		
Required Actions: The MCO's revised policy submitted after the virtual review is acceptable for the CAP for this element. The MCO must submit the finalized and implemented policy once approved.		
3. The MCO may not request disenrollment of a member because of an adverse change in the member's health status or because of the member's: • Utilization of medical services.	• LA.ELIG.02_-_Disenrollment_PP.pdf pg. 3	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
• Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCO's ability to furnish services to the member or to other members. *42 CFR §438.56(b)(2)* 2022 Contract Citations: 11.10.1.3; 11.11.4.1 2023 Contract Citations: 2.3.13.3.4		
4. The MCO may initiate disenrollment of any member's participation in the MCO on one or more of the following grounds: • When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department • Upon termination or expiration of the Contract • Death of the member • Confinement of the member in a facility or institution when confinement is not a covered service under the Contract *42 CFR §438.56(b)(1)* 2022 Contract Citations: 11.11.6.1; 11.11.6.2; 11.11.6.7 2023 Contract Citations: 2.3.12.3.2; 2.3.13.2	• LA.ELIG.02_-_Disenrollment_PP.pdf pg. 3	☒ Met ☐ Not Met
5. The MCO shall not request disenrollment for reasons other than those stated in the Contract. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.	• LA.ELIG.02_-_Disenrollment_PP.pdf pg. 3	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
42 CFR §438.56(b)(3) 2022 Contract Citations: 11.11.4.2 2023 Contract Citations: 2.3.13.3.5		
6. If the Department approves the MCO's disenrollment request, the MCO gives the member written notice of the proposed disenrollment. *42 CFR §438.56(f)(1)* 2022 Contract Citations: 11.11.4.4; 11.11.4.8 2023 Contract Citations: 2.3.13.3.7	• LA.ELIG.02_-_Disenrollment_PP.pdf pg. 4	☒ Met ☐ Not Met
7. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the MCO's service area; – The MCO does not (due to moral or religious objections) cover the service the member seeks; – The member needs related services to be performed at the same time, not all related services are available from the MCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; – Poor quality of care; – Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; – The Contract between the MCO and LDH is terminated;	• LA.ELIG.02_-_Disenrollment_PP.pdf pgs. 1 & 2	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– Lack of access to MCO covered services as determined by LDH; – The member's active specialized behavioral health provider ceases to contract with the MCO; or – Any other reason deemed to be valid by LDH and/or its agent. • Without cause at the following times: – During the disenrollment period offered to members at the start of the Contract – During the 90 days following the date of the member's initial enrollment with the MCO or during the 90 calendar days following the date the Enrollment Broker sends the member notice of that enrollment, whichever is later – At least once every 12 months thereafter – Upon automatic reenrollment if temporary loss (90 calendar days) of eligibility has caused the member to miss the annual disenrollment opportunity – When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]) *42 CFR §438.56(c)-(d)(2)* 2022 Contract Citations: 11.11.3; 11.11.3.1; 11.11.3.2 2023 Contract Citations: 2.3.13.2		

Results for Standard I—Enrollment and Disenrollment						
Total	Met	6	X	1.0	=	6.0
	Not Met	1	X	0.0	=	0.0
Total Applicable		7	**Total Score**		=	6.0

Total Score ÷ Total Applicable	=	**85.7%**

CY 2021 Review CAP

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. In compliance with applicable quality assurance and utilization management standards: *42 CFR 438.208* Contract: 6.19.4.2	**2022 MCO Document Submission:** • LA.CM.01.02_Care_Plan_Development_and_Implementation.pdf pg.1 and 6 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 26	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—This requirement is not addressed by the Care Plan Development and Implementation Process or the Care Management Program Description.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree; Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 30		
2023 CAP Review Findings: LHCC submitted the Care Management Program Description policy and procedure, which the MCO revised in May 2023. The MCO added language stating that the MCO's treatment plan must also follow applicable quality assurance and utilization management standards.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208* Contract: 6.19.4.3	**2022 MCO Document Submission:** • LA.CM.01.02_Care_Plan_Development_and_Implementation.pdf pg.6 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 30	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, three (3) files met the requirement and seven (7) files were not applicable. Of the 10 behavioral health case management files reviewed, two (2) files met the requirement and eight (8) files were not applicable. This requirement is not addressed by the Care Plan Development and Implementation Process or the Care Management Program Description.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree; Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 30 Monthly audits of staff on elements: • CM managers review dashboard with staff on monthly 1:1's • Increased staffing over the last several months		
2023 CAP Review Findings: The CAP for this element is no longer applicable with the implementation of the MCO's 2023 LDH contract. LHCC submitted the Care Management Program Description policy and procedure, which the MCO revised in May 2023 to include the requirements of its 2023 LDH contract. The MCO added language stating that the MCO's members' individualized treatment plans are reviewed and revised upon reassessment of functional need. It also stated that the plan of care (POC) revisions will occur at least at the frequency required in the Tiered Case Management requirements; when an enrollee's circumstances or needs change significantly (new problem, goal, barrier, or acuity change); or at the request of the enrollee, parent, or legal guardian.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above). *42 CFR 438.208* Contract: 6.19.4.4	**2022 MCO Document Submission:** • LA.CM.01.02_Care_Plan_Development_and_Implementation.pdf pg. 1 • LA.CM.01_-_Care_Management_Program_Description (3).pdf, pgs 28 and 30 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 26 & 27	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, all 10 files met the requirement. This requirement is partially addressed by the Care Plan Development and Implementation Process on page 1 and the Care Management Program Description on pages 28 and 30.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.		
2022 MCO Comments: Agree: • Added to document policy "LA.CM.01 Care_Management_Program_Description_IPRO updates.pdf", pg 32. • Care Managers were educated on importance of identifying all providers involved in member's care as well as guidelines on when to follow-up with providers regarding care plan updates.		
2023 CAP Review Findings: LHCC submitted the Care Management Program Description policy and procedure, revised in May 2023. The MCO added language stating that the MCO's person-centered integrated POC, developed by the MCO care manager, shall be completed within 30 calendar days of provider treatment plan development and include all medically necessary services such as specialized behavioral health services and primary care services identified in the member's treatment plans. The Care Management Program Description policy and procedure also stated that the individual treatment plan is developed by the enrollee's primary care provider (PCP) and/or other lead provider, as appropriate, with enrollee participation, and in consultation with any specialists caring for the enrollee.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
4. The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider. *42 CFR 438.208* Contract: 6.28.2; 6.28.2.1	**2022 MCO Document Submission:** • LA_Healthcare_Connections_Provider_Manual_2021 • CoordinationAndContinuity.pdf pg. 56 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 26	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, nine (9) files met the requirement. One (1) file (BH#8) did not meet the requirement: the member identified a PCP in the assessment, but there is no documentation in the file that LHCC attempted outreach to this provider. This requirement is partially addressed by the LA Healthcare Connections 2021 Provider Manual on page 56.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination. Additionally, LHCC should ensure that communication is established with identified PCPs.		
2022 MCO Comments: Agree: • Added to document policy "LA.CM.01 Care_Management_Program_Description_IPRO updates.pdf", pg 32 • Care Managers were educated on importance of identifying all providers involved in member's care as well as guidelines on when to follow-up with providers regarding care plan updates.		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that the POC shall include all medically necessary services identified by the enrollee's providers as well as the care coordination and other supports to be provided by LHCC. The Care Management Program Description policy and procedure also stated that behavioral health care coordination will be incorporated in the care plan as needed.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH. *42 CFR 438.208* Contract: 6.30.0	**2022 MCO Document Submission:** • LA.UM.16 - Continuity and Coordination of Services.pdf pg. 1 • Member-Handbook-Integrated -.pdf pg. 11 **2023 MCO Document Submission:** • LA.UM.16_Continuity_and_Coordination_of_Services_.pdf pgs. 1 & 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Continuity and Coordination of Services Policy.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.		
2022 MCO Comments: Agreed; Updated the policy to reflect verbiage to include additional language "LA.UM.16 Continuity and Coordination of Services_UM Additions.docx" pg 1 and 2		
2023 CAP Review Findings: The MCO's Continuity and Coordination of Services policy and procedure, which the MCO revised in December 2022, stated that the plan will provide continuity of care and care transition activities to ensure a continuum of care approach to providing healthcare services to enrollees. The plan shall have a process to coordinate the delivery of MCO-covered services for which it is responsible with services that are provided through fee-for-service, another LDH contractor, or by community and social support providers as required by 42 CFR §438.208(b)(2)(iv). The plan shall ensure appropriate provider choice within the plan's provider network and coordination with out-of-network providers, as needed, for continuity of care. The plan shall engage in continuity of care activities to ensure that network providers and the plan's staff members are kept informed of the enrollees' treatment needs, changes, progress, or problems. The policy also stated that the plan creates interventions to support effective interactions between enrollees and providers, as well as identifies and addresses interactions that are not effective. The plan shall monitor service delivery through enrollee surveys, medical and treatment record reviews, and explanations of benefits (EOBs) to identify and overcome barriers to primary and preventive care that an enrollee may encounter. The plan shall implement a CAP with its providers on an as needed basis and as determined by LDH.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses. *42 CFR 438.208* Contract: 6.30.2.3	**2022 MCO Document Submission:** • LA.UM.16 - Continuity and Coordination of Services.pdf pg. 2 **2023 MCO Document Submission:** • LA.UM.16_Continuity_and_Coordination_of_Services_.pdf pg. 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, all 10 files met the requirement. Of the 10 behavioral health case management files reviewed, all 10 files met the requirement. The requirement is partially addressed by the ICC Rounds system screenshots, the ICC Rounds Schedule, and the Continuity and Coordination of Services Policy on page 2.		
2022 Compliance Review Recommendation: The requirement is partially addressed by the ICC Rounds system screenshots, the ICC Rounds Schedule, and the Continuity and Coordination of Services Policy on page 2.		
2022 MCO Comments: Agree: • Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 26 • Added to document policy LA.UM.16 Continuity and Coordination of Services_UM Additions" pg 3 to reflect verbiage to include additional language		
2023 CAP Review Findings: The MCO's Continuity and Coordination of Services policy and procedure, which the MCO revised in December 2022, stated that the plan shall ensure enrollees are provided information on how to contact the person designated to assist with the coordination of their care.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. Coordinate care between network PCPs and specialists; including specialized behavioral health providers; Coordinate care for out-of-network services, including specialty care services; Coordinate MCO provided services with services the member may receive from other health care providers. *42 CFR 438.208* Contract: 6.30.2.4; 6.30.2.5; 6.30.2.6	**2022 MCO Document Submission:** • LA.UM.16 - Continuity and Coordination of Services.pdf pgs. 7 and 8 **2023 MCO Document Submission:** • LA.UM.16_Continuity_and_Coordination_of_Services_.pdf pgs. 5 & 6	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the DCFS Rounds document and the Continuity and Coordination.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination.		
2022 MCO Comments: Agree: • Updated the policy to reflect verbiage to include additional language "LA.UM.16 Continuity and Coordination of Services_UM Additions" pg 8		
2023 CAP Review Findings: The MCO's Continuity and Coordination of Services policy and procedure, which the MCO revised in December 2022, stated that the ICT will facilitate communication and coordination between the PCP and specialists, including behavioral health providers; will share assessment results and identified needs with other care entities who serve plan enrollees; and coordinate with Federally Qualified Health Centers (FQHCs)/rural health clinics (RHCs) and school-based clinics when providing services to enrollees. The policy also stated that the plan will evaluate the need for out-of-network services for the provision of care and that the ICT will facilitate coordination of services between the non-participating provider and the enrollee's PCP and other network specialists to ensure appropriate care coordination.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
8. The individualized treatment plans must be: 6.19.4.1 Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment. *42 CFR 438.208* Contract: 6.19.4.1	**2022 MCO Document Submission:** • LA.CM.01.02_Care_Plan_Development_and_Implementation.pdf pg. 2 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 26	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Care Management Program Description on page 32 and the LA Healthcare Connections 2021 Provider Manual on page 56.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy with the missing portion of the requirement included in the verbiage. It is acknowledged that LHCC has taken steps to address this requirement in its entirety; however, this will not change the current review determination. Additionally, LHCC should ensure that communication with the PCP is established in order to acquire the individualized treatment plan.		
2022 MCO Comments: Agree: • Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 30 • CM process updated to request treatment plan again, if not received with initial request upon enrollment		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that an individual treatment plan was developed by the enrollee's PCP and/or other lead provider as appropriate, with enrollee participation, and in consultation with any specialists caring for the enrollee. For enrollees with special health care needs (SHCN), the treatment plan shall be submitted to the enrollee's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
9. Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate. *42 CFR 438.208* Contract: 6.36.9.1.7	**2022 MCO Document Submission:** • LA_Healthcare_Connections_Provider_Manual_2021.pdf pgs. 106 and 107 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 35	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the LA Healthcare Connections Provider Manual on pages 106 and 107.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination		
2022 MCO Comments: Agree: Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 37		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that the goal of the MCO's emergency department (ED) diversion program was to decrease inappropriate ED utilization through the redirection of enrollees to appropriate levels of care, including referral to community behavioral health specialists for behavioral health emergencies.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
10. Documenting authorized referrals in the MCO's clinical management system. *42 CFR 438.208* Contract: 6.36.9.1.10	**2022 MCO Document Submission:** • Referrals 6.36.9.1.10_1.pdf • Referrals 6.36.9.1.10_2.pdf **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 20	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the referrals screenshots referenced.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree: Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 21		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that the care plan includes facilitation of enrollee referrals to resources and follow-up processes to determine whether enrollees act on referrals to community resources. The Care Management Program Description policy and procedure also stated under the "Information Systems" section that referrals, assessments, care plans, and all case management activities are documented in a central clinical documentation system, which facilitates automatic documentation of the individual's user name, along with date and time notations of all entries.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
11. Developing capacity for enhanced rates or incentives for integrated care by providers. *42 CFR 438.208* Contract: 6.36.9.1.11	**2022 MCO Document Submission:** • LA-Healthcare_Connections_Provider_ Manual_2021 pdf page 89 **2023 MCO Document Submission:** • LA.QI.23_-_Physician_Incentive_Plan_PP_.pdf pg. 1	☐ Met ☒ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the LA Healthcare Connections Provider Manual and the Amendment of the Provider Contract.		
2022 Compliance Review Recommendation: LHCC submitted documentation that shows how this requirement is communicated to providers; however, in addition to the communication component, the structure component in the form of a policy, procedure, or program description is needed. LHCC should create a policy, procedure, or program description to address this requirement.		
2022 MCO Comments: Agree: LA.QI.43 Physician Incentive Plan provides a general overview of the incentives for providers and Medicaid behavioral health value-based program description provides an overview of the program for behavioral health providers with a physical health component.		
2023 CAP Review Findings: The MCO submitted the Physician Incentive Plan (P4P) policy and procedure, revised in June 2023. The purpose statement of the policy included that the purpose was to implement a pay-for-performance program that delivers direct rewards to practitioners for providing quality and cost-effective care that promotes a medical home and emphasizes prevention and self-management. The policy did not describe the MCO's development of capacity for enhanced rates for incentives for integrated care by providers. After the virtual review, the MCO submitted the Physician Incentive Plan (P4P) policy and procedure that was updated after the virtual review (October 16, 2023), which included the added language regarding including enhanced payments and/or incentives and included integrated care by providers in the purpose statement.		
2023 CAP Review Required Actions: The MCO must submit evidence of review and approval by LDH of the October 16, 2023, updates to the Physician Incentive Plan (P4P) policy and procedure.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
12. Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures. *42 CFR 438.208* Contract: 6.36.9.1.12	**2022 MCO Document Submission:** • BH Screening Tools-National 6.36.8 & 6.36.9.1.12.pdf • LA_Healthcare_Connections_Provider_Manual_2021.pdf pgs. 85 and 86 • Care Management Learning Compass.pdf pgs. 176, 183-188, and 205 **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 22 • LA_Healthcare_Connections_Provider_Manual.pdf pg. 84	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Care Management Learning Compass, the BH Screening Tools presentation, the training website screenshot, and the provider orientation slide.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree: Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", pages 26		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that all case management staff members are provided training upon hire and as needed regarding care management assessments and screenings, which included identification and screening of behavioral health conditions and referral procedures. The MCO also submitted the 2023 Provider Manual. The provider manual stated under the "Clinical Training" section that clinical development and training teams will provide training for network providers and stakeholders within the MCO's network. It stated that topics offered to providers included but were not limited to behavioral health/physical health screening and referrals.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
13. Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team. *42 CFR 438.208* Contract: 6.36.9.1.13	**2022 MCO Document Submission:** • ICC Rounds 6.36.9.1.13.pdf • ICC Rounds 6.36.9.1.13_2.pdf • ICC Rounds Schedule.pdf **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 12	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—The requirement is partially addressed by the ICC Rounds system screenshots and by the ICC Rounds Schedule.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree: Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", page 19		
2023 CAP Review Findings: The MCO's Care Management Program Description policy and procedure, revised in May 2023, stated that case management staff members shall conduct case management rounds at least monthly, which included the behavioral health care managers and behavioral health medical directors.		
2023 CAP Review Required Actions: None.		

Coverage and Authorization of Services: CFR 438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication. *42 CFR 438.208* Contract: 6.36.9.1.14	**2022 MCO Document Submission:** • DCFS Rounds 6.36.9.1.14_1.pdf • DCFS Rounds 6.36.9.1.14_2.pdf **2023 MCO Document Submission:** • LA.CM.01_Care_Management_Program_Description_.pdf pg. 12 & 13	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the DCFS Rounds document.		
2022 Compliance Review Recommendation: LHCC submitted post-interview an update to their policy to include this requirement. It is acknowledged that LHCC has taken steps to address this requirement; however, this will not change the current review determination.		
2022 MCO Comments: Agree: Added to document policy "LA.CM.01_-_Care_Management_Program_Description_Updated 072722.docx", page 19		
2023 CAP Review Findings: The MCO's Care Management Program Description, revised in May 2023, stated that case management staff members participate in regular collaborative meetings at least yearly, or as needed, with LDH representatives for the purpose of coordination and communication.		
2023 CAP Review Required Actions: None.		

Coverage and Authorization of Services/Utilization Management CFR 438.438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials. *42 CFR 438.210* Contract: 8.5.4.1.2.1	**2022 MCO Document Submission:** • LA.UM.07 Adverse Determination (Denial) Notices.pdf, pg 1 <u>Post interview added:</u> • UM file review files 1 & 7 • The Correspondence Unit team will begin to use the readability analyzer. This is a tool that estimates the readability of a passage of text using the Flesch Reading Ease, Fog Sale Level, Flesch-Kincaid Grade level and other metrics. • Also per the LDH's Marketing and Member Education Companion Guide:, we are able to remove some language including the MCO's name, proper names (drug names, procedure names, and similar, Medicaid and Medicad/ dental terms with 3+ syllables. The CU team was trained to use this tool on 7/21/2022. We will use Microsoft word Flesch Kincaid reading level as a back-up. <u>Additional documentation:</u> • Correspondence Unit Process WP-7212022.pdf, pg 8, 10, 12, 14, and 15 **2023 MCO Document Submission:** • LA.UM.07_Adverse_Determination_Denial_Notices_.pdf pg. 1 **Virtual Review Follow-Up Documentation Review:** • LA.UM.07_Adverse_Determination_Denial_Notices_.pdf pgs. 1 and 3	☐ Met ☒ Not Met

Coverage and Authorization of Services/Utilization Management CFR 438.438.210		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2022 Compliance Review Finding: *Partially Met* Eight (8) of 10 files met the requirements; the remaining 2 files did not have language that appeared to be easily understood. Case 1 and 7 Fisher and Brumfield. This requirement is addressed in the Adverse Determination (Denial) Notices policy and procedure, but was only partially met in the file review.		
2022 Compliance Review Recommendation: The plan provided the language in the MCO comments section and an updated document showing how their correspondence unit will meet this going forward. No further action is required.		
2022 MCO Comments: Agree. Updated Work Process previously submitted to IPRO		
2023 CAP Review Findings: The MCO's Adverse Determination (Denial) Notices policy and procedure, revised in December 2022, stated that the plan shall notify the enrollee and provider in writing, using language that is easily understood by the enrollee, of decisions to deny a service authorization request; to authorize a service in an amount, duration, or scope that is less than requested; and include the specific reason/rationale for the determination, as well as the availability, process, and time frames for appeal of the decision. The Adverse Determination (Denial) Notices policy and procedure did not state that the notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this request for proposal (RFP) for member written materials. The policy did not include: • The adverse benefit determination the MCO intends to make. • The right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination.		
2023 CAP Review Required Actions: The MCO must update the policy to indicate that the notice of action to all members shall be consistent with requirements found in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of the RFP for member written materials or add to the policy: • The adverse benefit determination the MCO intends to make. • The right of the enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider. *42 CFR 438.224* Contract: 12.18.1	**2022 MCO Document Submission:** • Not applicable to LHCC **2023 MCO Document Submission:** • LA.CONT.23_Provider_Termination_.pdf pg. 2	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Provider Termination Policy and the sample member notification letters provided.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a policy.		
2022 MCO Comments: Agree. State requirement addressed in policy LA.CONT.23_Provider Termination (Page 3)		
2023 CAP Review Findings: The MCO's Provider Termination policy, dated April 11, 2023, stated that LHCC will give written notice of termination of a provider contract within 15 calendar days after receipt of issuance of the termination notice to members who received their care from or were seen regularly by the terminated provider.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances. *42 CFR 438.224* Contract: 12.18.2	**2022 MCO Document Submission:** • Not applicable to LHCC **2023 MCO Document Submission:** • LA.MBRS.27_Member_Advisory_of_Provider_Contract_Termination_or_Limitation_.pdf pg. 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Provider Termination Policy and the sample member notification letters provided.		
2022 Compliance Review Recommendation: The entity should incorporate this requirement into a policy.		
2022 MCO Comments: Agree. State requirement addressed in policy LA.MBRS.27_Member_Advisory_of_Provider_Contract_Termination_or_Limitation_Policy (Page 1)		
2023 CAP Review Findings: The MCO's Member Advisory of Provider Contract Termination or Limitation policy, dated February 16, 2023, stated that LHCC will provide notice to a member, or the parent/legal guardian and the involved state agency as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven calendar days from the date LHCC becomes aware of such, if it is prior to the change occurring. Also on page one of the policy, under the "Timely Notice" section, it included that failure to provide notice prior to the dates of termination will be allowed when a provider becomes		

Enrollee Rights and Protections CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
unable to care for members due to an illness, a provider dies, a provider moves from the service area and fails to notify LHCC, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon LHCC becoming aware of the circumstances.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. Revocation of the provider's home and community-based services license or behavioral health service license. *42 CFR 438.608* Contract: 7.6.2.2.1	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers who have had a revocation of their provider's license.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. Exclusion from the Medicaid program. *42 CFR 438.608* Contract: 7.6.2.2.2	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 U.S.C. §1320a-7 or 42 U.S.C. §1320c-5, or who are otherwise barred from participation in the Medicaid and/or Medicare program.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. Termination from the Medicaid program. *42 CFR 438.608* Contract: 7.6.2.2.3	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers who have experienced termination from the Medicaid program.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
4. Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41). *42 CFR 438.608* Contract: 7.6.2.2.4	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers who are currently undergoing withholding of Medicaid reimbursement as authorized by the Department's Surveillance and Utilization Review Subsystems (SURS) Rule (LAC 50:I.Chapter 41).		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50). *42 CFR 438.608* Contract: 7.6.2.2.5	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers who fail to timely renew their licenses. The policy did not specifically reference the Home and Community-Based Services Providers Licensing Standards Rule (LAC 48:I Chapter 50). It is recommended that the MCO add the appropriate Rule reference to its Fraud, Waste, and Abuse Plan.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. The Louisiana Attorney General's Office has seized the assets of the service provider. *42 CFR 438.608* Contract: 7.6.2.2.6	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not contract or shall terminate contracts with providers whose assets the Louisiana Attorney General's Office has seized.		
2023 CAP Review Required Actions: None.		

Fraud Waste and Abuse CFR 438.608		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories. *42 CFR 438.608* Contract: 7.6.2.3	**2022 MCO Document Submission:** • LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022.pdf (PG. 29) **2023 MCO Document Submission:** • LA.COMP.16_Fraud,_Waste,_and_ Abuse_Plan_.pdf pg. 15	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Not Met*—The FWA Plan effective during the 2021 review period does not address this requirement. While it is addressed in LA.COMP.16_LHCC_FWA_Plan UPDATED POLICY 2022, the Reviewed/ Revised date of this document is indicated as 2/22, which is outside the review period.		
2022 Compliance Review Recommendation: No action is required by LHCC, as this issue was self-identified and added to the updated policy.		
2022 MCO Comments: We agree with the IPRO audit findings. The not met requirements were mitigated prior to the audit by updating the policy. LHCC discovered the policy effective date ended 12/31/2021. LHCC Compliance scheduled a review of the policy updates in the February 2022 Policy Committee meeting and self-disclosed the noncompliance during the audit.		
2023 CAP Review Findings: The MCO's Fraud, Waste, and Abuse Plan stated that LHCC shall not remit payment for services provided under its contract with LDH to providers located outside of the United States. The term "United States" means the 50 states, the District of Columbia, and any United States territories.		
2023 CAP Review Required Actions: None.		

Results for Follow-Up on 2022 Deficiencies Corrective Action Plans							
Total	Met	=	22	X	1.0	=	22.0
	Not Met	=	2	X	0.0	=	0.0
Total Applicable		=	24	**Total Score**		=	22.0

Total Score ÷ Total Applicable	=	**91.7%**

Appendix C. 2023 Corrective Action Plan Template

Standard I—Enrollment and Disenrollment			
Requirements—HSAG's Findings and MCE Required Corrective Actions			
Element 2: The MCO does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability. *42 CFR §438.3(d)(3-4)* 2022 Contract Citations: 11.10.1.3 2023 Contract Citations: 2.3.12.1; 2.3.12.3			
Findings: The MCO's redline version of the Eligibility Guidelines policy, dated October 16, 2023, stated that the plan shall not discriminate against individuals enrolled, or use any policy or practice that has the effect of discriminating against individuals, based on their health history; health status; need for healthcare services or adverse change in health status; or on the basis of age, religious belief, sex/gender, sexual orientation, gender identity, disability, race, color, or national origin. The policy originally submitted for review did not reference race, color, national origin, or disability. The original policy also referenced potential members but did not include enrolled individuals.			
Required Actions: The MCO's revised policy submitted after the virtual review is acceptable for the CAP for this element. The MCO must submit the finalized and implemented policy once approved.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			