LOUISIANA DEPARTMENT OF HEALTH

2023 External Quality Review Compliance Review

for

UnitedHealthcare Community

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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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 **UnitedHealthcare Community** (**UHC**). 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. If a requirement was not applicable to **UHC** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. 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*	*NA*	
Follow-Up on Corrective Action Plans (CAPs)From Prior Compliance Review	19	17	1	1	94.4%

M=*Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

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.

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

UHC achieved compliance in 17 of 18 applicable elements from the LDH-approved CY 2022 compliance review CAPs. **UHC** must implement the remaining approved CAP for the one element for which compliance was not achieved. Appendix B documents detailed findings of the review of the implementation of the **UHC**-approved CY 2022 compliance review CAPs.

Corrective Action Process

For any elements HSAG scored *Not Met*, **UHC** 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. Elements not applicable to the MCE were scored *NA* and were not included in the denominator of the total score.

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 17, 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

UHC 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 **UHC** 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 **UHC** into full compliance with the deficient requirements. **UHC** must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). **UHC**'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 **UHC** 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 **UHC** 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 **UHC** in its submitted CAP.

Appendix A. Conclusions and Recommendations

Standard I—Enrollment and Disenrollment

Strengths Related to Access and Timeliness	
+	The MCO's policies and procedures ensured that the MCO did not request disenrollment of a member because of an adverse change in the member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Opportunities for Improvement and Recommendations	
−	**Opportunities for Improvement:** The MCO's Louisiana Member Handbook for Integrated Health Services did not include the following requirements: **With Cause** • 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. **Without Cause** • 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]). • After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722. The MCO's UHC Disenrollment policy did not include the following requirements: • **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 (PCP) (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. – 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. – Any other reason deemed to be valid by LDH and/or its agent.

Opportunities for Improvement and Recommendations	
	• **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]). **Recommendations:** The MCO must ensure that the Louisiana Member Handbook for Integrated Health Services includes the following language: The member may request disenrollment as follows: • For cause at any time, including: – 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. • Without cause at the following times: – 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]). – After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722. The MCO must ensure the UHC Disenrollment policy includes the following language: 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 PCP (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.

Opportunities for Improvement and Recommendations	
	– 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. – 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]).

Appendix B. 2023 Compliance With Standards Review Tool

This appendix includes the completed review tool that HSAG used to evaluate **UHC**'s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring **UHC**'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	• 2.3.15_Eligibility and Enrollment _Member Enrollment and Disenrollment Policy-Section 5 paragraph 1 and Section 5A • Marketing and Enrollee Education Policy, page 24 regarding the enrollment function responsibility of the Enrollment broker.	☒ 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	• 2.3.15_Eligibility and Enrollment Member Enrollment and Disenrollment Policy Section 5 Section 5A • Marketing and Enrollee Education Policy, page 6	☒ Met ☐ Not Met
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. • 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	• UHC Member Disenrollment Policy_LA_2019 specifies the disruptive behavior portion procedure #2 page 2 and procedure 8-page 3 includes utilization' and diminished mental health capacity and disruptive behaviors (CFR) and others mentioned in 2.3.13.3.4 • LA_IntegratedHealthServices_Handbook-Eng_v4, page 67 regarding disruptive behavior	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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	• UHC Member Disenrollment Policy_LA_2019, procedure 4 addresses this somewhat but is written with "limiting" language to procedure 2 and 3. • LA_IntegratedHealthServices_Handbook-Eng_v4, page 66 regarding contract termination and page 67 regarding moving into a long-term care facility.	☒ 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. *42 CFR §438.56(b)(3)* *42 CFR §438.56(b)(3)* 2022 Contract Citations: 11.11.4.2 2023 Contract Citations: 2.3.13.3.5	• UHC Member Disenrollment Policy_LA_2019 page 1, PP 2 in the policy section and page 2, procedures #2- #4	☒ Met ☐ Not Met
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(d)(5)* 2022 Contract Citations: 11.11.4.4; 11.11.4.8 2023 Contract Citations: 2.3.13.3.7	• UHC Member Disenrollment Policy_LA_2019, page 3 procedure #5 references member notification; however, it does not include "after approval by LDH department"	☒ Met ☐ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
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; – 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:	• Marketing and Enrollee Education Policy, pg. 9 regarding disenrollment rights and pg. 10 regarding more information on religious objections. • LA_IntegratedHealthServices_Handbook-Eng_v4, page 66-moral or religious grounds; out of area move; obtaining certain services; poor quality; first 90 days; annual open enrollment and lack of accesses • UHC Member Disenrollment Policy_LA_2019 page 1, PP 3 in the policy section (covers the 90 days provision	☐ Met ☒ Not Met

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– 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		
HSAG Findings: The MCO stated that UHC "did not have moral or religious objections to the program services. "For Cause" member requests were reviewed by UHC's operation and/or clinical team depending on the circumstances. An attempt to resolve the member's issue was made with the member, and the outcome of the attempt to resolve the situation was reported to LDH. If a "for cause" exception was approved by LDH, UHC would continue to provide services for the enrollee until the disenrollment date was received via the daily 834 eligibility file. If an internal process issue was identified based on the research done by UHC, corrective action would be taken." Without cause disenrollments were processed when received via the daily 834 enrollment files from LDH via Maximus. The MCO's Louisiana Member Handbook for Integrated Health Services did not include the following requirements: **With Cause** • 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.		

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
Without Cause • 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]). • After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722. The MCO's UHC Disenrollment policy did not include the following requirements: • **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 PCP (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. – 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. – 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]).		

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**

Required Actions: The MCO must ensure that the Louisiana Member Handbook for Integrated Health Services includes the following language:

The member may request disenrollment as follows:

- For cause at any time, including:
  - 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.
- Without cause at the following times:
  - 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]).
  - After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722.

The MCO must ensure the UHC Disenrollment policy includes the following language:

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 PCP (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.
  - 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.
  - Any other reason deemed to be valid by LDH and/or its agent.
- Without cause at the following times:

Standard I—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the MCO**	**Score**
– 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]).		

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

Availability of Services CFR 438.206		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. Working with MCO case managers to develop plans of care for members receiving case management services. Contract: 7.8.2.10	**2022 MCO Document Submission:** • UHC_LA Acute Care Provider Manual 2021 Page 27, 63-64 **2023 MCO Document Submission:** • [AS7.8.2.10-.12SuppDoc1] update 090823, page 2, last 2 bullets in 2.9.1 General Provider Network Requirements • [AS7.8.2.10-.12SuppDoc2] update 090823, Page 24, procedure 6C	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual.		
2022 Compliance Review Recommendation: UHC should add the language to relevant policies.		
2022 MCO Comments: Plan agrees with recommendation. We will incorporate into the Network Development Plan for medical and BH.		
2023 CAP Review Findings: The MCO's 2022 Network Provider Development Management Plan included the requirement to "collaborate with case managers to develop plans of care for members receiving case management services". The MCO also submitted the 2022–2023 Specialized Behavioral Health Network Provider Development and Management Plan, which included a section titled "Integration of Care Initiative." The section stated that "provider trainings/JOC(s) have included Integration of Care and Primary Care responsibilities, including but not limited to managing and coordinating medical and behavioral health care needs in a timely manner, referring to specialists and how we may assist when needed, developing plans of care (POCs) to address risks and working with our care managers to develop the POC(s) for those members in care management and participating in our case management team/Interdepartmental team meetings as needed".		
2023 CAP Review Required Actions: None.		

Availability of Services CFR 438.206		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. Participating in the MCO's case management team, as applicable and medically necessary. Contract: 7.8.2.11	**2022 MCO Document Submission:** • Participating in the MCO's case management team, as applicable and medically necessary. **2023 MCO Document Submission:** • [AS7.8.2.10-.12SuppDoc1] update 090823, page 2, last 2 bullets in 2.9.1 General Provider Network Requirements • [AS7.8.2.10-.12SuppDoc2] update 090823, Page 24, procedure 6C	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual.		
2022 Compliance Review Recommendation: UHC should add the language to relevant policies.		
2022 MCO Comments: Plan agrees with recommendation. We will incorporate into the Network Development Plan for medical and BH.		
2023 CAP Review Findings: The MCO's 2022 Network Provider Development Management Plan included the requirement to "participate with case management team, as applicable and medically necessary". The MCO's 2022–2023 Specialized Behavioral Health Network Provider Development and Management Plan included a section titled "Integration of Care Initiative." The section stated that "provider trainings/JOC(s) have included Integration of Care and Primary Care responsibilities, including but not limited to managing and coordinating medical and behavioral health care needs in a timely manner, referring to specialists and how we may assist when needed, developing plans of care (POCs) to address risks and working with our care managers to develop the POC(s) for those members in care management and participating in our case management team/Interdepartmental team meetings as needed".		
2023 CAP Review Required Actions: None.		

Availability of Services CFR 438.206		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services. Contract: 7.8.2.12	**2022 MCO Document Submission:** • UHC_LA Acute Care Provider Manual 2021 Page:68-72 **2023 MCO Document Submission:** • [AS7.8.2.10-.12SuppDoc1] update 090823, page 12, Primary Care Provider Responsibilities section. • [AS7.8.2.10-.12SuppDoc2] update 090823 update 090823, Page 25, Procedures 13 a.-d.	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is not addressed in any submitted policy or procedures. This requirement is addressed in the Care Provider Manual.		
2022 Compliance Review Recommendation: UHC should add the language to relevant policies.		
2022 MCO Comments: Plan agrees with recommendation. We will incorporate into the Network Development Plan for medical and BH.		
2023 CAP Review Findings: The MCO's 2022 Network Provider Development Management Plan included the requirement of "conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services". The MCO's 2022–2023 Specialized Behavioral Health Network Provider Development and Management Plan included a section titled "Enhancing Detection of Behavioral Disorders in Primary Care Settings (ONGOING) (all ages)." The section stated that "primary care providers (PCPs) play a vital role in integrated care as they are often the first contact for enrollees in need of behavioral health services. Our strategy focuses on ensuring providers have the education and tools they need to screen for and treat behavioral health conditions based on evidence-based best practices. We provide our **Behavioral Health Toolkit for Medical Providers**, **featuring screening tools, checklists, best practices, and Clinical Guidelines**. For example, the Toolkit supports PCPs in completing initial questionnaires assessments for mental health and SUD using screening tools such as the PHQ-9 for depression, GAD-7 for anxiety, the Vanderbilt scale for ADHD, ACE and PEARLS for trauma, and CRAFFT and DAST-10 for substance use."		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. 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. Contract: 6.19.4.4	**2022 MCO Document Submission:** • NCM Policy Rider LA 002_pdf; – Page 1 - Section III Policy Statement, – Pages 3-5 - B1 through B9 • Chronic Illness Program Process_pdf; – Section 10 Pages 5 & 7 **2023 MCO Document Submission:** • [CCC6.19.4.1;.4SuppDoc] Pages 1,6	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, nine (9) files met the requirement, and one (1) file was not applicable. Of the 10 behavioral health case management files reviewed, five (5) files met the requirement, and five (5) files were not applicable. This requirement is partially addressed by the Case Management Process Policy on pages 3 through 5 and the Chronic Illness Program Process on pages 5 and 7; these documents do not address the timeframe stipulated by the requirement. The Case Management Process, submitted after the on-site interview, also partially addresses the requirement, but due to the revision date, it cannot be accepted as part of this review.		
2022 Compliance Review Recommendation: This requirement is partially addressed by the Case Management Process Policy on pages 3 through 5 and the Chronic Illness Program Process on pages 5 and 7; these documents do not address the timeframe stipulated by the requirement. The Case Management Process, submitted after the on-site interview, also partially addresses the requirement, but due to the revision date, it cannot be accepted as part of this review.		
2022 MCO Comments Plan agrees with recommendation. We will incorporate into policy and procedure.		
2023 CAP Review Findings: The MCO's Case Management process, with a review date of April 13, 2023, was updated to include that special health care needs (SHCN) members' treatment plans are submitted 30 days following the completion of the initial assessment or annual reassessment. The process included language stating that a POC is completed in person within 30 calendar days of identification and includes assessment of the home environment and priority social determinants of health.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2. 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; Contract: 6.28.2; 6.28.2.1	**2022 MCO Document Submission:** • NCM Policy Rider LA 002_pdf; – Page 3 - Section B1 – Page 5 - Section C3 **2023 MCO Document Submission:** • [CCC6.28.2.1SuppDoc1], page 2-(as a note, there are other highlights in the document we were not able to removed. Although, the entire communication is responsive, yellow highlights address PCP/provider outreach • (CCC6.28.2.1SuppDoc2) update 090823, Instructions for Use tab **Virtual Review Follow-Up Documents** • HSAG Element #2 Response-Chart Audit #1 • HSAG Element #2 Response-Chart Audit #2	☒ Met ☐Not Met
2022 Compliance Review Finding: *Partially Met* Of the 10 case management files reviewed, three (3) files met the requirement, two (2) files were not applicable, and five (5) files did not meet the requirement. Of the 10 behavioral health case management files reviewed, eight (8) files met the requirement, and two (2) files were not applicable. This requirement is addressed by the Case Management Process on page 3.		
2022 Compliance Review Recommendation UHC should ensure that staff are outreaching to the PCP/providers to collaborate and coordinate care for members.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to work on this documentation.		
2023 CAP Review Findings: The MCO submitted a screen shot of the care management system that reflected the clinical monthly chart audit. The screen shot identified the types of information collected in the care management system. The MCO also submitted a copy of a clinical blast to internal staff members. The blast included a statement that the MCO was contractually required to share the POC with the provider involved in the member's care. It also directed staff members to manually add a goal to each POC for continuity of care, stating the initial POC will be		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
shared with the provider as well as the required updates to the POC as outlined in the contract language included in the clinical blast. The MCO submitted sample chart audit results that demonstrated implementation of the MCO's CAP. HSAG recommends that the MCO formalize the information included in the clinical blast in a care management/case management policy or procedure.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
3. Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge. Contract: 6.30.211.2	**2022 MCO Document Submission:** • UHC_Coordination of BH Care document.pdf – Page 2 section 3.5 **2023 MCO Document Submission:** • [CCC6.30.2.11.2SuppDoc] update 090823, page 3 Medical Case Transition…section, pages 7-8, Member Engagement section and page 10 Emergency Room Visits section **Virtual Review Follow-Up Documents** • CCC6.30.2.11.2SuppDoc C-S BH CCA Transition of Care Job Aid Update 10.18.23 (page 12)	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 behavioral health case management files reviewed, four (4) files met the requirement, and six (6) files were not applicable. This requirement is partially addressed by the Coordination of Behavioral Healthcare Policy on page 2. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review		
2022 Compliance Review Recommendation: UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum.		
2023 CAP Review Findings: The MCO's Transitions of Care Process was updated after the virtual compliance review session. The updated policy included the correct time frame for care manager follow-up with members with a behavioral health-related diagnosis of within 72 hours following discharge.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
4. Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan. Contract: 6.30.2.11.4	**2022 MCO Document Submission:** • UHC_Coordination of BH Care document.pdf – Page 2 section 3 **2023 MCO Document Submission:** • [CCC6.30.2.11.4; 6.36.3,5SuppDoc1] Pages 7 • [CCC6.30.2.11.4SuppDoc2] Page 5, UM CA Process, and page 7, Contract Language section **Virtual Review Follow-Up Documents** • CCC6.30.2.11.4; 6.36.3,5SuppDoc1_LA UHC CS Coordination Continuity and Transition of Behavioral Health Care Addendum_Update_10.18.23 (see Item 4, page 7 sections D and E) • CCC6.30.2.11.4SuppDoc3_Discharge Planning-04.26.23_Update_10.18.23 (what specifically is addressing the auditors request)	☐ Met ☒ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 behavioral health case management files reviewed, one (1) file met the requirement and nine (9) files were not applicable. This requirement is partially addressed by the Coordination of Behavioral Healthcare Policy on page 2; this policy does not include the 30-day timeframe stated in the requirement. This requirement is addressed by the Coordination, Continuity, and Transition of Behavioral Health Care Addendum on pages 3 through 4; however, due to the document date, it cannot be accepted as part of this review.		
2022 Compliance Review Recommendation: UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
2023 CAP Review Findings: The MCO's Coordination, Continuity and Transition of Behavioral Health Care Addendum policy, which was revised on December 12, 2022, did not address the requirement that the discharge plan should be in place 30 calendar days prior to discharge. It also did not include the requirement of follow-up with the receiving provider(s) and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers. The MCO's Transitions of Care Process was revised by the MCO on October 17, 2023, after the virtual compliance review. The updates included: • The Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, which includes referral to community providers prior to reentry into the community including but not limited to members in the Louisiana Medicaid Program pre-release program. • Regarding residential levels of care (e.g., PRTF, SUD residential treatment, TGH), the Utilization Management (UM) team works with the member and provider(s) as the member approaches the end discharge of continued stay for residential treatment to develop concrete and proactive discharge plans, which include aftercare providers addressing the member's treatment needs during the next recommended level of care and/or living situation. UM outreaches the treating provider and assists with identifying and/or linking providers needed for aftercare and/or community resources. The discharge plan is completed no later than 30 calendar days prior to discharge. • The Care Management team follows up with the member, legal representative, and treating providers identified in the aftercare/discharge plan to ensure the member is receiving services. The MCO also submitted the Optum United Behavioral Health Discharge Planning Policy. The policy included the process for identifying the needs of the member following discharge from facility-based treatment, and, as appropriate, ensuring that the member has the means to meet those needs; and ensuring that the facility has scheduled for the member an outpatient appointment for follow-up care with an appropriately licensed outpatient practitioner within seven days of discharge from an inpatient level of care, and, in the event the facility has not done so, assisting the member, when necessary, with scheduling an appointment within seven days of discharge. The auditor determined that the CAP language was added after the virtual review interview session. Therefore, the score will remain as *Not Met*. The policy changes meet the CAP requirements.		
2023 CAP Review Required Actions: The MCO updated the Coordination, Continuity and Transition of Behavioral Health Care Addendum policy on October 17, 2023. The updated policy included the requirement that the discharge plan should be in place 30 calendar days prior to discharge. The policy update also included the requirement to follow up with the receiving provider(s) and the member/guardian to ensure the member was contacted by and receiving services from aftercare providers. The MCO must submit a finalized, approved, and implemented policy to close the element CAP.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
5. 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. Contract: 6.19.4.1	**2022 MCO Document Submission:** • Louisiana Care Management Process_pdf; – Page 3 **2023 MCO Document Submission:** • [CCC6.19.4.1;.4SuppDoc] Page 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Of the 10 case management files reviewed, one (1) file met the requirement, four (4) files were not applicable, and five (5) files did not meet the requirement. Of the 10 behavioral health case management files reviewed, seven (7) files were not applicable and two (2) files did not meet the requirement. This requirement is partially addressed by the Louisiana Care Management Process on page 3; this process does not address the timeframe stipulated by the requirement.		
2022 Compliance Review Recommendation: UHC should edit the process to include the entire requirement. Additionally, UHC should ensure that staff are outreaching PCP/providers properly in order to obtain treatment plans for members.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to work on this documentation.		
2023 CAP Review Findings: The MCO's Case Management process was revised on April 13, 2023. The process included the following requirements: • Individualized patient-Centered Care Plans developed by the member's Primary Care Provider, Specialists and Behavioral Health Providers as appropriate with- RN, BHS or CHW depending on member tiering level, • Individualized Patient Centered Care Plan developed with member participation, and in consultation with any specialists caring for the member. • SHCN members: treatment plans submitted 30 days following the completion of the initial assessment or annual reassessment. • CM staff outreach for coordination of care with PCP/providers, Specialists and Behavioral Health Providers (when applicable) using available avenues to include but not limited to: telephonic, email, direct mail or use of Provider portal to develop treatment plans for members.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
6. In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed. Contract: 6.36.3	**2022 MCO Document Submission:** • UHC_Access Standards and Care Advocacy Center (CAC) Hours of Opertaion.pdf – Pages 2-3 Section 6 **2023 MCO Document Submission:** • [CCC6.30.2.11.4; 6.36.3,5SuppDoc1] Page 4	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Access Standards and Care Advocacy Center Hours of Operation Policy on pages 2 through 3; the policy does not address the follow-up portion of the requirement. The Utilization Management of Behavioral Health Benefits Addendum does not address the requirement. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review.		
2022 Compliance Review Recommendation: UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2023 CAP Review Findings: The MCO's Coordination, Continuity and Transition of Behavioral Health Care Addendum policy was revised on December 20, 2022. The policy stated that "in any instance when a member presents to UHC LA, including calling UHC LA's toll-free number listed on the member's identification (ID) card, and a member is in need of emergency behavioral health services, UHC LA instructed the member to seek help from the nearest emergency medical provider". UHC LA initiated follow-up with the member within 48 hours to establish that appropriate services were accessed.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
7. The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's overall care plan with the member's behavioral health and primary care provider. Contract: 6.36.5	**2022 MCO Document Submission:** • Community Care Activity Tracking_docx – Page 1, both Medical and BH **2023 MCO Document Submission:** • [CCC6.30.2.11.4; 6.36.3,5SuppDoc1] C.4 on page 4	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Community Care Activity Tracking document. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum and the member handbook do not address the requirement. **Response to MCO comments:** We cannot accept LA UHC C-S Coordination Continuity and Transition of Behavioral Health Care Addendum -Final 07.27.2022 as a policy for this annual compliance review since it went in effect after the review timeframe.		
2022 Compliance Review Recommendation: UHC should address this requirement in a policy and a process.		
2022 MCO Comments: Disagree. Please refer to page 5 section C.4 of LA UHC C-S Coordination Continuity and Transition of Behavioral Health Care Addendum -Final 07.27.2022		
2023 CAP Review Findings: The MCO's Coordination, Continuity and Transition of Behavioral Health Care Addendum was revised on December 20, 2022. The policy addendum stated that UHC LA included documentation in the member's medical record that attempts were made to engage the member's cooperation and permission to coordinate the member's overall care plan with the member's behavioral health and PCP(s).		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
8. Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. Contract: 6.36.9.1.5	**2022 MCO Document Submission:** • 6_36_9_1_5_Narrative_docx **2023 MCO Document Submission:** • [CCC6.36.9.1.5,11SuppDoc] update 090523, page 1, information on procedure code G9002 and page 6, number 11 **Virtual Review Follow-Up Documents** • CCC6.36.9.1.5,11_Integrated Health Home Template_Final_V66 October 2022_Update_10.18.23 • CCC6.36.9.1.5,11_BHPi Program Overview Dual Brand Flyer_BH3909a_ FINAL 3.3.22_Update_10.18.23	☐ Met ☐ Not Met ☒ NA
2022 Compliance Review Finding: *Not Met* This requirement is not addressed in any policy or procedure. During the review, UHC acknowledged that this is a requirement to develop and needs additional work.		
2022 Compliance Review Recommendation: UHC should address this requirement in a policy and a process.		
2022 MCO Comments: Plan agrees with recommendation. We will address with a policy and a process.		
2023 CAP Review Findings: The MCO's In Lieu of Service Description Template did not address that "in lieu of services" includes capacity for enhanced rates or incentives to behavioral health clinics to employ a PCP (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. The MCO submitted the Integrated Behavioral Health Home Provider Incentive Agreement, which was updated on October 18, 2023, after the virtual compliance review. The policy included that the "care team consisted of a multidisciplinary team of clinical and non-clinical professionals, directed and led by a licensed clinician, tasked with providing Integrated Behavioral Health Home Services, as further described throughout in this Agreement (collectively, the "Services"). Care teams shall include physicians/primary care providers and/or psychiatrists (or mid-level prescribers with behavioral health expertise, with physician oversight), Care Coordinators (CCs), Case Managers (CM) (nurses, social workers, behavioral case managers, professional		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
counselors), and Peer/Family Support Specialists, and may also include other licensed professionals or Allied staff (pharmacists, nutritionists, licensed addiction professionals, Community Health Workers, Wellness Coaches, Health Coaches, Recovery Coaches, etc.). While UBH does not require specific staffing ratios a ratio of 1:250 is recommended for RNs and 1:50 is recommended for other care managers or allied staff. The performance metrics for outcome payments in the agreement included: • *Ambulatory Care: ED Visits (AMB-HH)* • *Inpatient Utilization (IPU)* • *Plan All-Cause Readmission Rate (PCR)* • *Follow-Up After Hospitalization for Mental Illness (FUH-7)* • *Eye Exam for Patients with Diabetes (EED)* • *Child and Adolescent Well-Care Visits (WCV)* • *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)* • *Rate of Inpatient Behavioral Health Admissions (TPI)* • *Medication Adherence – Mood Stabilizers (MA-MS)* • *Medication Adherence – Antipsychotics (MA-AP)* • *Medication Adherence – Antidepressants (MA-AD)"* The MCO also submitted the BHPi Program Overview Dual Brand Flyer. The flyer described the behavioral health provider incentive BHPi program. It provided examples of how providers could achieve bonus payments based on measure outcomes. Note: During the virtual review, the MCO noted that this requirement is no longer included in the 2023 contract. HSAG reviewed this with LDH and recommended this requirement be scored as NA. LDH agreed with this update.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
9. Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use. Contract: 6.36.9.1.6	**2022 MCO Document Submission:** • UHC_Confidential Exchange of Information form.pdf – Entire document **2023 MCO Document Submission:** • [CCC6.36.9.1.6SuppDoc1] update 090523, the entire form as the additional form requested by the EQRO • [CCC6.36.9.1.6SuppDoc2] update 090823, pages 8-9, Sharing Information with LDH & Providers • [CCC6.36.9.1.6SuppDoc3] update 090823, entire document as requested by EQRO	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the Confidential Exchange of Information Form. The Coordination, Continuity, and Transition of Behavioral Health Care Addendum addresses the requirement; however, due to the document date, it cannot be accepted as part of this review.		
2022 Compliance Review Recommendation: UHC should continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to implement the Coordination, Continuity, and Transition of Behavioral Health Care Addendum to meet this requirement.		
2023 CAP Review Findings: The MCO's Louisiana C & S Medicaid Case Management document was revised by the MCO on September 5, 2023. On page eight and nine, the document included the process for sharing information with LDH and providers. The process steps in the document included: • For all members enrolled in CM, if the POC or assessment outcomes are requested in writing by LDH and/or a provider, share the requested information via secure delivery email or fax or via Community Care.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
• Obtain permission from the member before sending following the Release of Information Request Work Aid. Document in Community Care. • Outreach the provider to verify the provider's correct address where the member is seen, as well as the provider's fax / email to ensure secure delivery. • Share **only** the documents contained in the request, and nothing more. • Refer to Sending Secure Email to Members > **Sending Secure Email in Outlook**. The MCO's Release of Information (ROI) Requests article had a revision date of September 8, 2023. The article described the process to receive a member's or other individual's approval to share information.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
10. Developing capacity for enhanced rates or incentives for integrated care by providers; Contract: 6.36.9.1.11	**2022 MCO Document Submission:** • UHC_Provider Incentive Rates **2023 MCO Document Submission:** • [CCC6.36.9.1.5,11SuppDoc] update 090523, page 1, information on procedure code G9002 **Virtual Review Follow-Up Documents** • CCC6.36.9.1.5,11_Integrated Health Home Template_Final_V66 October 2022_Update_10.18.23 • CCC6.36.9.1.5,11_BHPi Program Overview Dual Brand Flyer_BH3909a_ FINAL 3.3.22_Update_10.18.23	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement Is partially addressed by the Provider Incentives Rates document. The Integration of Physical and Behavioral Health Through Whole Person Care Policy does not address the requirement.		
2022 Compliance Review Recommendation: UHC should address this requirement in a policy and a process.		
2022 MCO Comments: Plan agrees with recommendation. We will address with a policy and a process.		
2023 CAP Review Findings: The MCO's In Lieu of Service Description Template did not address that "in lieu of services" includes capacity for enhanced rates or incentives to behavioral health clinics to employ a PCP (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients. The MCO submitted the Integrated Behavioral Health Home Provider Incentive Agreement, which was updated on October 18, 2023, after the virtual compliance review. The policy included that the "care team consisted of a multidisciplinary team of clinical and non-clinical professionals, directed and led by a licensed clinician, tasked with providing Integrated Behavioral Health Home Services, as further described throughout in this Agreement (collectively, the "Services"). Care teams shall include physicians/primary care providers and/or psychiatrists (or mid-level prescribers with behavioral health expertise, with physician oversight), Care Coordinators (CCs), Case Managers (CM) (nurses, social workers, behavioral case managers, professional counselors), and Peer/Family Support Specialists, and may also include other licensed professionals or Allied staff (pharmacists, nutritionists,		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
licensed addiction professionals, Community Health Workers, Wellness Coaches, Health Coaches, Recovery Coaches, etc.). While UBH does not require specific staffing ratios a ratio of 1:250 is recommended for RNs and 1:50 is recommended for other care managers or allied staff. The performance metrics for outcome payments in the agreement included: • *Ambulatory Care: ED Visits (AMB-HH)* • *Inpatient Utilization (IPU)* • *Plan All-Cause Readmission Rate (PCR)* • *Follow-Up After Hospitalization for Mental Illness (FUH-7)* • *Eye Exam for Patients with Diabetes (EED)* • *Child and Adolescent Well-Care Visits (WCV)* • *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)* • *Rate of Inpatient Behavioral Health Admissions (TPI)* • *Medication Adherence – Mood Stabilizers (MA-MS)* • *Medication Adherence – Antipsychotics (MA-AP)* • *Medication Adherence – Antidepressants (MA-AD)"* The MCO also submitted the BHPi Program Overview Dual Brand Flyer. The flyer described the behavioral health provider incentive BHPi program. It provided examples of how providers could achieve bonus payments based on measure outcomes.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
11. Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication. Contract: 6.36.9.1.14	**2022 MCO Document Submission:** • 6.36.9.1.12_Narrative_docx **2023 MCO Document Submission:** • [CCC6.36.9.1.14SuppDoc], page 1	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the 2022 LA IPRO EQRO Compliance Review Audit Narrative. The Integration of Physical and Behavioral Health Through Whole Person Care Policy does not address the requirement.		
2022 Compliance Review Recommendation: UHC should address this requirement in a policy and a process.		
2022 MCO Comments: Plan agrees with recommendation. We will address with a policy and a process.		
2023 CAP Review Findings: The MCO's Participate in LDH Meetings as Required policy was revised by the MCO on January 1, 2023. The purpose statement in the policy stated that the purpose of the policy is to establish a protocol for, and ensure compliance with, LDH; and for the UHC leadership team to participate in regular collaborative meetings with LDH representatives for the purpose of coordination and communication activities.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
12. Procedures and criteria for making referrals to specialists and subspecialists; Contract: 6.40.6	**2022 MCO Document Submission:** • LA-Integrated-Health-Services-Handbook - Page 22 **2023 MCO Document Submission:** • [CCC6.40.6SuppDoc] Page 2, policy provision A.1.a and A.4.a,b.; Page 3, procedure 5.b., pages 4 and Page 5-Section D	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the provider handbook.		
2022 Compliance Review Recommendation: UHC should address this requirement in a policy and a process.		
2022 MCO Comments: Plan agrees with recommendation. We will address with a policy and a process.		
2023 CAP Review Findings: The MCO submitted the Delegated Case Management/Care Coordination policy. The policy stated that "provider relations distributed the provider administrative manuals, which provide instructions on how to use services and include the required or expected communication and notification of admissions, referrals and other transitions, and exchange of information between providers, specialists, subspecialists, consumers and UHC. The policy also stated that clinical staff facilitated the coordination and delivery of care and services between the consumer, their primary care provider (or NP/PA for institutionalized consumers), the Inpatient Care Team (ICT), multiple programs and services, specialists, subspecialists and other providers via individualized plans of care for consumers with chronic or complex conditions, or for consumers who require multiple sources of treatment or multiple types or levels of care and for members at high risk of having a transition, in order to reduce that possibility." The policy described the role of the PCP in managing care transitions as "the PCP was primarily responsible for coordinating the overall health care of the assigned members. The PCP provided ongoing primary care services and referred consumers for specialty, institutional care, and other health services as appropriate. The PCP, in conjunction with UHC staff, made and followed-up on referrals, as appropriate, to community-based and social service agencies for support services. CM may initiate specialty/ specialists, therapy, institutional care, or other health services referral through contact with PCP or by member request. The PCP was primarily responsible for coordinating the overall health care of the assigned members."		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
13. The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services. Contract: 6.42.1	**2022 MCO Document Submission:** • LA CNS Care Management Program Description 2021 - FINAL • DM UHC HF Taking Charge Booklet • DM UHC Diabetes Taking Charge Booklet • DM UHC COPD Taking Charge Booklet • DM UHC CAD Taking Charge Booklet • DM UHC Asthma Taking Charge Booklet • DM UHC Taking Charge of Asthma Guide for Teens and Parents (ages 12-18) • DM UHC Taking Charge of Asthma Guide for Child and Parents (ages 0-11) **2023 MCO Document Submission:** • [CCC6.42.1SuppDoc]-the entire document supports to corrective action for the HCV Program	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the UnitedHealthcare Community & State Care Management Program Description, the submitted toolkits, and the booklet educational materials; however, there was no documentation of hepatitis C included in the CCMP.		
2022 Compliance Review Recommendation: UHC should develop a chronic care management program for hepatitis C.		
2022 MCO Comments: Plan agrees with recommendation. We will develop a chronic care management program for hepatitis C.		
2023 CAP Review Findings: The MCO's 2023 HCV Plan was described as the chronic care management program for members diagnosed with hepatitis C. The program was not specific to high utilizers but encompassed all members diagnosed with hepatitis C. In addition, the MCO's Case Management process, which was last reviewed on April 13, 2023, included stratification levels (tier levels) for chronic conditions: chronic obstructive pulmonary disease [COPD], asthma, Coronary artery disease [CAD], chronic pain, sickle cell, diabetes, and heart failure.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
The process included a table that provided a description of the stratification levels for each chronic condition, including member criteria and associated interventions based on minimum clinical risk scores and impactable/actionable score minimums.		
2023 CAP Review Required Actions: None.		

Coordination and Continuity of Care: CFR 438.208		
Requirement	**Evidence as Submitted by the MCO**	**Score**
14. Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions; Contract: 6.42.4.5	**2022 MCO Document Submission:** • LA CNS Care Management Program Description 2021 - FINAL - Page 6-11/19 **2023 MCO Document Submission:** • [CCC6.42.4.5SuppDoc] Page 1 **Virtual Review Follow-Up Documents** • Case Management -LA002 Case Management Policy and Process • Chronic Conditions Intervention and Member Education Guides	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the UnitedHealthcare Community & State Care Management Program Description.		
2022 Compliance Review Recommendation: UHC should add detail to the program description on the stratification levels for each chronic condition.		
2022 MCO Comments: Plan agrees with recommendation. We will address stratification levels for each chronic condition for in the program description.		
2023 CAP Review Findings: The MCO's Case Management process was last reviewed on April 13, 2023. The process included stratification levels for chronic conditions: COPD, asthma, CAD, chronic pain, sickle cell, diabetes, and heart failure. The process included a table that provided a description of the stratification levels for each chronic condition, including member criteria and associated interventions based on minimum clinical risk scores and impactable/actionable score minimums.		
2023 CAP Review Required Actions: None.		

Provider Selection: CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2). The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year. Contract: 7.6.3.2; 7.14.1	**2022 MCO Document Submission:** • UHC_Credentialing Plan.pdf Section 4 and Section 5 • UHC_Louisiana Addendum to Credentialing Policies.pdf **2023 MCO Document Submission:** • [PS7.6.3.2SuppDoc]-Documentation supporting the quarterly report of credentialing and recredentialing metrics	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—Five (5) of five (5) initial credentialing files met the NCQA health plan accreditation standards. Four (4) of five (5) re-credentialing files met the NCQA health plan accreditation standards. One (1) recredentialing, file did not meet the timeliness standard (every 3 years). This requirement is addressed in UHC's Network Provider Management, Credentialing and Recredentialing Policy.		
2022 Compliance Review Recommendation: The plan should conduct on-going internal reviews of credentialed provider records to ensure that providers are re-evaluated in a timely manner.		
2022 MCO Comments: Plan agrees with recommendation. We will continue to monitor closely compliance with timeliness standards.		
2023 CAP Review Findings: The MCO provided the [PS7.6.3.2SuppDoc] document, which was a fourth quarter 2022 medical credentialing and recredentialing report. The report displayed the Louisiana medical credentialing and recredentialing counts, turnaround time (TAT) assessment, and the listing that 100 percent of the quarter's files met applicable TATs. The report included a spreadsheet snapshot of statistics		

Provider Selection: CFR 438.214		
Requirement	**Evidence as Submitted by the MCO**	**Score**
by month including the state TAT requirement of 60 days, internal goal of less than the state's target, average days actual, stats met or exceeded, total records, and percentage met of applicable TAT. The document supported the requirement representing how the plan conducts ongoing internal reviews of credentialed provider records to ensure that providers are reevaluated in a timely manner.		
2023 CAP Review Required Actions: None.		

Enrollee Rights and Protection: CFR 438.224		
Requirement	**Evidence as Submitted by the MCO**	**Score**
1. The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.).	**2022 MCO Document Submission:** • LA-Integrated-Health-Services-Handbook- Entire Document • LA Physical Health Handbooks- Entire Document • LA_MentalHealth_SubstanceUseHandbook-Eng- Entire Document **2023 MCO Document Submission:** • [ERP12.12.1SuppDoc] Pages 6-13	☒ Met ☐ Not Met
2022 Compliance Review Finding: *Partially Met*—This requirement is partially addressed by the member handbooks.		
2022 Compliance Review Recommendation: The entity should incorporate the member handbook requirements into a member handbook policy or a broader written materials policy.		
2022 MCO Comments: Plan agrees with recommendation. We will write into a policy a procedure format.		
2023 CAP Review Findings: The MCO's MKTG & ENROLLEE EDUC 100 policy, dated November 15, 2022, included the requirement that the MCO "shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3". The policy specifically stated that "UnitedHealthcare Community Plan shall adhere to the requirements for the Member Handbook, Welcome Member Newsletter, MCO Member ID Card, and Provider Directory as specified in this Contract, its attachments, and in accordance with 42 CFR §438.10".		
2023 CAP Review Required Actions: None.		

Results for Follow-Up on 2022 Deficiencies Corrective Action Plans							
Total	Met	=	17	X	1.0	=	17.0
	Not Met	=	1	X	0.0	=	0.0
	NA	=	1	X	0.0	=	0.0
Total Applicable		=	18	**Total Score**		=	17.0

Total Score ÷ Total Applicable	=	**94.4%**

Appendix C. 2023 Corrective Action Plan Template

Standard I—Enrollment and Disenrollment
Requirements—HSAG's Findings and MCE Required Corrective Actions
Element 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; – 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
HSAG Findings: The MCO stated that UHC "did not have moral or religious objections to the program services. "For Cause" member requests were reviewed by UHC's operation and/or clinical team depending on the circumstances. An attempt to resolve the member's issue was made with the member, and the outcome of the attempt to resolve the situation was reported to LDH. If a "for cause" exception was approved by LDH, UHC would continue to provide services for the enrollee until the disenrollment date was received via the daily 834 eligibility file. If an internal process issue was identified based on the research done by UHC, corrective action would be taken." Without cause disenrollments were processed when received via the daily 834 enrollment files from LDH via Maximus. The MCO's Louisiana Member Handbook for Integrated Health Services did not include the following requirements: **With Cause**

Standard I—Enrollment and Disenrollment
• 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. **Without Cause** • 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]). • After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722. The MCO's UHC Disenrollment policy did not include the following requirements: • **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 PCP (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. – 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. – 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]).
Required Actions: The MCO must ensure that the Louisiana Member Handbook for Integrated Health Services includes the following language: The member may request disenrollment as follows: • For cause at any time, including: – 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. • Without cause at the following times: – Upon automatic reenrollment if temporary loss (90 calendar days) of eligibility has caused the member to miss the annual disenrollment opportunity.

Standard I—Enrollment and Disenrollment			
– When the Department has imposed sanctions on the MCO (consistent with 42 CFR §438.702[a][4]). – After LDH notifies the MCO that it intends to terminate the contract as provided in 42 CFR §438.722. The MCO must ensure the UHC Disenrollment policy includes the following language: 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 PCP (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. – 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. – 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]).			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			