



**2025 External Quality Review
Compliance Review**

for

Magellan of Louisiana

December 2025



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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 (CR) 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 CR, 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 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.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Apr 2, 2025.

Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for Magellan of Louisiana (Magellan). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

Table 1-1—Summary of Scores for Each Standard

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
I	Enrollment and Disenrollment Requirements and Limitations	12	5	5	0	7	100%
II	Member Rights and Confidentiality	24	23	23	0	1	100%
III	Member Information	19	16	14	2	3	88%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	11	9	2	4	82%
VI	Coordination and Continuity of Care	12	12	12	0	0	100%
VII	Coverage and Authorization of Services	23	20	18	2	3	90%
VIII	Provider Selection	19	19	11	8	0	58%
IX	Subcontractual Relationships and Delegation	6	0	0	0	6	NA
X	Practice Guidelines	6	6	5	1	0	83%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	16	2	0	89%
Total Compliance Score		227	200	177	23	27	89%

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

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

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

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 Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

Table 2-1—CR Standards

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I— Enrollment and Disenrollment Requirements and Limitations	§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	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
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 CR 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).

* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs 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 CR, HSAG developed data collection tools, referred to as “CR tools,” to document the review. The content in the tools was selected based on applicable federal and state-specific 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, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for 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 systems (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.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

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 CR tool, as described in the Data Aggregation and Analysis section below.
- 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, 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, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

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*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

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.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR 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, 2024–December 31, 2024
Information obtained through interviews	August 2025–September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

3. Corrective Action Plan Process







Magellan 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 Magellan to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. 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 Magellan into full compliance with the deficient requirements. Magellan must use this template to submit its CAP to bring any elements scored as Not Met into compliance with the applicable standard(s). Magellan's CAP template and evidence of implementation must be submitted to the HSAG SAFE site **no later than 60 calendar days from 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 Magellan will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought Magellan 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. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by Magellan in its submitted CAP.

Appendix A. Conclusions and Recommendations

Strengths	
	The MCE’s policies and procedures ensured that the MCE 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. Furthermore, the MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations.
	The MCE received 100 percent compliance with Standard II—Member Rights and Confidentiality, indicating that members were receiving timely and adequate access to information that could assist them in access care and services.
	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
	The MCE received 100 percent compliance with Standard VI—Coordination and Continuity of Care, demonstrating that the MCE had adequate processes in place for its case management program.
	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had a robust health information system for processing and managing member data, provider data, and claims processing, while ensuring data security and facilitating data reporting.
	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.

Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations	
	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.



Appendix B. 2025 Compliance Review Tool

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



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Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
Disenrollment Requested by the MCE		
<p>1. The MCE may request disenrollment of a member in the following circumstances:</p> <ul style="list-style-type: none"> a. <i>When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department</i> b. <i>Upon termination or expiration of the Contract</i> c. <i>Death of the member</i> d. <i>Confinement of the member in a facility or institution when confinement is not a covered service under the Contract</i> <p>PAHP: <i>The Contractor may request involuntary disenrollment of an enrollee if the enrollee’s utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee’s ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).</i></p> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.</i> <p style="text-align: right;">42 CFR §438.56(b)(1) 42 CFR §457.1212</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • State-specific workflow for MCE-initiated disenrollment requests • Member materials, such as the member handbook • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Magellan Health Revised Intent to Discharge Procedure 12.18.2024 pg 2 • LA Admin Code pg 1-2 • CSoC Member Handbook p. 19 “Disenrollment from the CSoC Program” • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the <i>MCE</i>) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6	<p><i>Description of Process</i>)-N/A There is no case example, because Magellan does not do.</p> <p>Additional Documentation:</p> <ul style="list-style-type: none"> Intent to Discharge Letter No Face to Face 	
<p>MCE Description of Process: The only reasons a member can be discharged from the CSoc Program are listed in the LA Admin Code. The guardian either signs a voluntary disenrollment form, the youth is clinically ineligible on the CANS, or the youth falls into one of the other “Intent to Discharge” reasons and Magellan has to mail a letter to the guardian notifying them their child will be discharged.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE does not request disenrollment because of:</p> <p>MCO & PAHP:</p> <ol style="list-style-type: none"> a. An adverse change in the member’s health status; or b. Because of the member’s health diagnosis c. The member’s utilization of medical services d. The member’s diminished mental capacity e. The member’s pre-existing medical condition f. The member’s refusal of medical care or diagnostic testing g. The member’s attempt to exercise his/her rights under the Contractor’s Grievance system h. The member’s attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>) N/A, There are no cases to report. Magellan does not complete. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>enrollment in the MCE seriously impairs the MCE’s ability to furnish services to either this particular member or other members).</p> <p>PIHP:</p> <ul style="list-style-type: none"> a. The member's adverse change in health status b. The member’s utilization of medical services c. The member’s diminished mental capacity d. The member’s uncooperative or disruptive behavior resulting from his or her special needs <p style="text-align: right;">42 CFR §438.56(b)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5</p>	<ul style="list-style-type: none"> • Magellan Health Revised Intent to Discharge Procedure 12.18.2024 pg 2 • LA Admin Code pg 1-2 	
<p>MCE Description of Process: The only reasons a member can be discharged from the CSoc Program are listed in the LA Admin Code. The guardian either signs a voluntary disenrollment form, the youth is clinically ineligible on the CANS, or the youth falls into one of the other “Intent to Discharge” reasons and Magellan has to mail a letter to the guardian notifying them their child will be discharged.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract.</p> <p>MCO & PAHP:</p> <ul style="list-style-type: none"> a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request 	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.</p> <p>PIHP:</p> <p>a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may not disenroll Coordinated System of Care (CSoC) members for any reason other than discharge from CSOC. Eligible members may choose to no longer participate in CSOC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge.</p> <p style="text-align: right;">42 CFR §438.56(b)(3) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan Health Revised Intent to Discharge Procedure 12.18.2024 pg 2 LA Admin Code pg 1-2 Intent to Discharge and Notification of Discharge Training 	
<p>MCE Description of Process: The only reasons a member can be discharged from the CSOC Program are listed in the LA Admin Code. The guardian either signs a voluntary disenrollment form, the youth is clinically ineligible on the CANS, or the youth falls into one of the other “Intent to Discharge” reasons and Magellan has to mail a letter to the guardian notifying them their child will be discharged.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Disenrollment Requested by the Member		
<p>4. The member may request disenrollment from the MCE as follows:</p> <p>a. Without cause, at the following times:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>MCO:</p> <ul style="list-style-type: none"> i. During the disenrollment period offered to Enrollees at the start of the contract. ii. During the 90 days following the date of the member’s initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later. iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter. v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act. vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. <p>PAHP:</p> <ul style="list-style-type: none"> i. During the 90 days following the date of the member’s initial enrollment into the MCE, or during the 90 days following the date the State 	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • CSoC Discharge Form • Consent to Discharge Form • Notification of Discharge Disenrollment 	<input checked="" type="checkbox"/> NA



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>sends the member notice of that enrollment, whichever is later.</p> <p>ii. At least once every 12 months thereafter.</p> <p>iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.</p> <p>iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.</p> <p>v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p style="text-align: right;">42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA</p>		
MCE Description of Process:		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Procedures for Disenrollment		
<p>5. The following are causes for disenrollment:</p> <p>MCO:</p> <ul style="list-style-type: none"> a. The member moves out of the MCE’s service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; c. The member needs related services to be performed at the same time; not all related services are available from the MCE’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; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs; f. The Contract between the MCE and LDH is terminated; g. The member’s active specialized behavioral health provider ceases to contract with the MCE for reasons other than noncompliance with the Network Provider Agreement of this Contract; or h. Any other reason deemed to be valid by LDH and/or its agent. <p>PAHP:</p> <ul style="list-style-type: none"> a. The MCE does not (due to moral or religious objections) cover the service the member seeks; 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The member needs related services to be performed at the same time, not all related services are available from the MCE’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;</p> <p>c. Poor quality of care;</p> <p>d. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</p> <p>e. The Contract between the MCE and LDH is terminated;</p> <p>f. Any other reason deemed to be valid by LDH and/or its agent.</p> <p style="text-align: right;">42 CFR §438.56(d)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA</p>		
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>6. The member must request disenrollment by submitting an oral or written request (as required by the State):</p> <p>a. To the State or its agent; or</p> <p>b. To the MCE, if the State permits MCEs to process disenrollment requests.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> ● Policies and procedures ● Member materials, such as the member handbook ● Workflow delineating State and MCE responsibilities 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA	42 CFR §438.56(d)(1) 42 CFR §457.1212 <ul style="list-style-type: none"> Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) 	
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
7. When the MCE’s contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State. 42 CFR §438.56(d)(3)(i) 42 CFR §457.1212 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter, review conducted by the MCE, decision made by the MCE, reporting to the State) 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Use of the MCE’s Grievance Process		
<p>8. (If the State contract requires) The member must seek redress through the MCE’s grievance process before making a determination on the member’s request:</p> <p>a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State.</p> <p>b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Three case examples of a member request for disenrollment grievance record, including the resolution letter Referrals to the State for member termination from MCE Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>9. If the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Enrollment		
<p>10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems.</p> <p>MCO and PAHP:</p> <p>a. <i>The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Accessibility of Care Procedures pg 2 • CSoC Referral Workflow • Receiving a CSoC Direct Referral Call Procedure pg 1-2 • Receiving a CSoC Referral Call from HLP Procedure pg 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p><i>Populations that meet the conditions set forth in 42 CFR §438.50(a).</i></p> <p>PIHP:</p> <p>a. <i>The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member’s choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility.</i></p> <p style="text-align: right;">42 CFR §438.3(d)(1)</p> <p>MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2.</p>		
<p>MCE Description of Process: When a referral call comes in to Magellan, a Care Manager completes a Brief CANS and if the youth meets presumptive eligibility, the referral is sent out to the wraparound agency. Magellan builds a 30 day authorization for the wraparound agency and during the 30 day presumptive period, the wraparound agency is responsible for having a CANS, IBHA, and Freedom of Choice completed to determine clinical eligibility.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>11. The MCE 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.</p> <p style="text-align: right;">42 CFR §438.3(d)(3-4)</p> <p>MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoc Member Handbook p. 45 “Discrimination is Against the Law” • Accessibility of Care Procedures pg 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Magellan does not discriminate against anyone based on any information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>12. If the Department approves the MCE’s disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing.</p> <p>MCO:</p> <p>a. The notice shall include:</p> <ol style="list-style-type: none"> i. The reason for the disenrollment; ii. The effective date of the disenrollment; iii. An instruction that the Enrollee choose a new MCO; and iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Enrollment policies and procedures • Member notification letter template <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>PAHP:</p> <p>a. The notice shall include:</p> <p style="margin-left: 20px;">i. The reason for the disenrollment;</p> <p style="margin-left: 20px;">ii. The effective date;</p> <p style="margin-left: 20px;">iii. An instruction that the enrollee choose a new DBPM; and</p> <p style="margin-left: 20px;">iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(5)</p> <p>MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA</p>		
MCE Description of Process: NA		
HSAG Findings: The MCE followed the required disenrollment procedures that are specific to the CSoC program; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	5	X	1	=	5
	Not Met	=	0	X	0	=	0
	Not Applicable	=	7				
Total Applicable		=	5	Total Score	=	5	

Total Score ÷ Total Applicable	=	100%
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Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
General Rule		
<p>1. The MCE has written policies regarding member rights.</p> <p style="text-align: right;">42 CFR §438.100(a)(1) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Member rights policy-Corporate Policy, Member Handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook, pg. 2, “Acknowledgement and Receipt”, pg. 25, section 1 “Your right to information”. <p>Additional Documentation:</p> <ul style="list-style-type: none"> SII R2 Medicaid Enrollee Rights and Responsibilities Policy https://www.magellanoflouisiana.com/for-members/member-materials/rights-responsibilities/ 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The health plan’s written policy and procedure, member handbook.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it’s employees and contracted providers observe and protect those rights.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures- Provider materials, such as the provider manual, provider contract, and provider training materials 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.100(a)(2) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4</p>	<ul style="list-style-type: none"> Employee training materials- Auditing/oversight mechanisms-Grievance log over the time period of review with member rights grievances- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SII R2 Medicaid Enrollee Rights and Responsibilities Policy: Addresses federal and state requirements in Policy Statement (p. 2), Section III.O (p. 6), and Section V.A (p. 9). Oversight and education functions detailed in Sections I.C–D (pp. 3–4) and I.G (p. 4). SII R2 Member Rights MHS Organization Site Review pg 1 and section V SII R2 Member Rights LA CSOC Provider Handbook pr43 SII R2 Treatment Record Review Tool – Member Rights & Confidentiality Section: Contains highlighted fields used to audit provider documentation of member rights education and confidentiality protections. SII R2 Member Grievance Tracking Log – 2024 Member Rights: Documents grievances related to member rights, confirming the grievance system is used to identify and address potential rights violations. 	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Section 1557 Language Access - COM.1952.01.P – Procedure – Corporate Language Access Policy Telephonic Customer Service/Clinical quality Monitoring – QI.113.10 - Policy – Documents audits and monitoring of Customer Service along with coaching and reporting. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Training link Provider Handbook, page 43 and the network monitoring section. Treatment Record Reviews - QI.117.02 - Policy 	
<p>MCE Description of Process: Magellan complies with applicable federal and state laws protecting member rights through defined policies, provider and staff training, oversight tools, and grievance monitoring. Rights are detailed in the Medicaid Enrollee Rights and Responsibilities policy and reinforced through provider onboarding materials, including the Provider Handbook and Orientation. Oversight is conducted via the TRR and Site Visit tools, which audit compliance with documentation and communication of member rights. Member grievances tagged to rights concerns are tracked and reviewed to ensure protections are upheld across the provider network.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Specific Rights		
<p>3. The MCE complies with the requirements listed in the Member Rights Checklist.</p> <p style="text-align: right;">42 CFR §438.100(b-d) 42 CFR §457.1220</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures Member materials, such as the member handbook 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1	<ul style="list-style-type: none"> HSAG will also use the results of the Member Rights Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook, pg. 24-28. “Member Rights and Responsibilities.” <p>Additional Documentation:</p> <ul style="list-style-type: none"> Resubmitted checklist and documented additional evidence within checklist 	
<p>MCE Description of Process: The health plan’s policy and procedure on complying with the requirements listed in the member rights checklist, member handbook.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
General Rule		
<p>4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.</p> <p>a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO.</p> <p>b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures (should address all components of 45 CFR part 164 subpart E) Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>who is able to provide further information about matters covered by the notice required by 45 CFR §164.520.</p> <p>c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530.</p> <p>d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.</p> <p style="text-align: right;">42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E</p> <p>MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12</p>	<ul style="list-style-type: none"> • Employee-facing materials • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SII R4 Member Rights MHS Organization Site Review Section VI • SII R4 Member rights LA CSOC Provider Handbook pgs 42,43,59 • SIIR4 Member Rights Network Provider Agreement Section 5.5 • SII R4 Member Rights Ntwk Prov Medicaid Addendum Section 5.1.2 • SII R4 LA CSOC_Network Monitoring Ongoing Review Process pg 2 • PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 • PR-BA Minimum Necessary Uses and Disclosure of PHI-PR-BA.1711.06-Policy • PR-BA Authorization to use and Disclose PHI-PR-BA.1720.06-policy • PA-BA Chief Privacy Officer- PR-BA.1721.02-2024 • AUD Form-Medicaid Magellan CSOC Program • LA AUD Instructions 9.22.24 • 2024 Privacy Essentials Training • 2024 Privacy Essentials for New Hires 	



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Magellan Network Provider Agreement (Pg. 8, section 5.5) CSOC Provider Handbook (Pg. 24, 1st bullet, Pg 42, 4th bullet, pg.43, 2nd bullet, pg. 59, Our policy, 5th bullet) LA Magellan NTwk Pro Medicaid Addendum Exhibit F (pg. 7, 5.1.2) 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Use and Disclosure of PHI		
<p>5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows:</p> <ol style="list-style-type: none"> a. To the individual. b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c). 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedure Staff training materials Business associate agreement template One example of an executed business associate agreement <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 PR-BA Minimum Necessary Uses and Disclosure of PHI-PR-BA.1711.06-Policy PR-BA Authorization to use and Disclose PHI-PR-BA.1720.06-policy 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508.</p> <p>e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510.</p> <p>f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g).</p> <p style="margin-left: 40px;">45 CFR §164.502(a)(1-3)</p> <p style="margin-left: 40px;">45 CFR §164.502(a)(5)(i)</p> <p style="margin-left: 40px;">45 CFR §164.502(b)</p> <p style="margin-left: 40px;">45 CFR §164.506</p> <p style="margin-left: 40px;">45 CFR §164.508</p> <p style="margin-left: 40px;">45 CFR §164.510</p> <p style="margin-left: 40px;">45 CFR §164.512</p> <p style="margin-left: 40px;">45 CFR §164.514(d-g)</p> <p style="margin-left: 40px;">45 CFR §164.530(c)(2)(ii)</p> <p style="margin-left: 40px;">42 CFR §457.1110(a-b)</p> <p style="margin-left: 40px;">45 CFR §160 Subpart C</p> <p>MCO Contract: 6.22; 6.23</p> <p>PAHP Contract: 2.1.4.1; 2.1.4.2</p> <p>PIHP Contract: 20.12.2</p>	<ul style="list-style-type: none"> • 2024 Privacy Essentials Training (Pg 79, Additional Items to Consider, #1) • 2024 Privacy Essentials for New Hires • Magellan does not have any executed BAAs with subcontractors. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Provider Handbook • Network Provider Agreement and Addendum • MHS Organization Site Review • Site Visit 601650443 COMPASS BHVRL HLTH SVCS SVII • PR-BA.1702.032024 policy Pg 2 III & Pg 4 XI A • PR-BA Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Healthcare Operations 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Recommendations: HSAG recommends that the MCE update its PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 to include applicable CFR references.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI:</p> <p style="margin-left: 20px;">a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528.</p> <p style="margin-left: 20px;">b. When required by the Secretary to investigate or determine the MCE’s compliance with 45 CFR §160 subpart C.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.502(a)(2-4) 45 CFR §164.524 45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Business associate agreement template One example of an executed business associate agreement <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 (Pg. 2, V, A-C) 2024 Privacy Essentials Training Magellan does not have a business associate agreement at this time. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provider Handbook Network Provider Agreement and Addendum MHS Organization Site Review Site Visit 601650443 COMPASS BHVRL HLTH SVCS SVII PR-BA.1702.032024 policy Pg 2 III & Pg 4 XI A PR-BA Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Healthcare Operations 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		



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<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that the MCE update its PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 to include applicable CFR references.</p>		
<p>Required Actions: No action required.</p>		
Minimum Necessary		
<p>7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.</p> <p style="text-align: right;">45 CFR §164.502(b) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum-</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Three examples of requests for PHI from another covered entity (e.g., member’s previous MCE, dental benefits administrator, provider) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR-BA Minimum Necessary Uses and Disclosure of PHI-PR-BA.1711.06-Policy 2024 Privacy Essentials Training (Pg. 62-89) Magellan does not have an example of this type of request for the review time frame. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provider Handbook Network Provider Agreement and Addendum MHS Organization Site Review Site Visit 601650443 COMPASS BHVRL HLTH SVCS SVII PR-BA.1702.032024 policy Pg 2 III & Pg 4 XI A 	



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	<ul style="list-style-type: none"> PR-BA Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Healthcare Operations 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Recommendations: HSAG recommends that the MCE update its PR_BA General Rules for Uses and Disclosures of PHI-PR-BA.1701.05-2024 to include applicable CFR references.</p>		
<p>Required Actions: No action required.</p>		
<p>8. Minimum necessary does not apply to:</p> <ul style="list-style-type: none"> a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. <p style="text-align: right; margin-right: 20px;"> 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 </p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum- PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR-BA Minimum Necessary Uses and Disclosure of PHI-PR-BA.1711.06-Policy (Pg. 2, III A-E) 2024 Privacy Essentials Training (Pg. 62-89) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Use and Disclosures Requiring Authorizations		
<p>9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI, such use or disclosure must be consistent with the authorization.</p> <p>a. If a covered entity seeks authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization.</p> <p style="text-align: right;">45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4) 45 CFR Part 164 Subpart E 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum-</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • PR-BA Authorization to use and Disclose PHI-PR-BA.1720.06-policy • AUD Form-Medicaid Magellan CSOC Program • LA AUD Instructions 9.22.24 • Outside AUD – 2024-10-03 Email HornA • Magellan CSOC AUD – No examples to present. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: All signed AUDs are submitted to the PI Compliance officer for review and processing. Magellan AUDs are processed but outside AUDs are sent to legal (Chief Compliance Officer) for approval before processing.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Privacy Rights		
<p>10. The MCE complies with the member’s right to request privacy protection for PHI and the requirements under 45 CFR §164.522.</p> <p style="text-align: right;">45 CFR §164.522 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Process workflow • Member request form for privacy protection • Two examples of member’s request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • PR-BA Member Right to Request Privacy Protection for PHI PR-BA.1704.06 • 2024 Privacy Essentials for New Hires (Pg. 18) • Magellan has not received any request for Privacy Protection. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members and to members in requests.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The MCE complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.</p> <p>a. The MCE acts on a request for access no later than 30 days after receipt of the request.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • Process workflow 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member.</p> <p style="text-align: right;">45 CFR §164.524 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> Member request form to access PHI Two examples of member’s request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR-BA Member Right to Request Access to PHI, PR-BA.1705.08 2024 Privacy Essentials Training (Pg. 6) Member Right to request access form Magellan has not received a member request for access to their medical records. 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members and to members in requests.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. The MCE complies with the member’s right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526.</p> <ul style="list-style-type: none"> The MCE acts on the member’s request for an amendment no later than 60 days after receipt of such a request. <p style="text-align: right;">45 CFR §164.526 42 CFR §457.1110(e)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Process workflow Member request form to amend PHI Two examples of member’s request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	<ul style="list-style-type: none"> One example of a denial of an amendment and notification to the member <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR-BA Member Right to Request Amendment of PHI PR-BA.1706.04-2024 2024 Privacy Essentials Training (Pg. 6) Magellan requires all requests for amendment to be in writing. Member Right to request Amendment Denial Letter Magellan has not executed a request to amend PHI. 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members and to members in requests.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
13. The MCE complies with the member’s right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528. a. The MCE acts on the member’s request for an accounting, no later than 60 days after receipt of such a request.	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials Process workflow Member request form for an accounting of disclosures of PHI Mechanism to track disclosures (e.g., where reports to Adult Protective Services are 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j).</p> <p style="text-align: right;">45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>documented within the system for retrieval for the accounting of disclosure).</p> <ul style="list-style-type: none"> Two examples of member’s request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request Documentation to demonstrate how the record of the accounting of disclosures is retained <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Member Right to Request an Accounting of Disclosures of PHI, PR-BA.1707.03-2024 2024 Privacy Essentials Training (Pg. 6) Disclosure of PHI form Disclosure of PHI instructions Business Associate Disclosure of PHI form Request for an accounting of disclosure form 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members and to members in requests.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Breach of Unsecured PHI		
<p>14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to have been accessed, acquired, used, or disclosed as a result of such breach.</p> <p style="margin-left: 20px;">a. Breach and unsecured PHI are as defined in 45 CFR §164.402.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.402 45 CFR §164.404(a)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Breach notification letter template Incident risk assessment tool Unauthorized disclosure/breach tracking mechanism List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Incident risk assessment tool Unauthorized disclosure/breach tracking mechanism 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the MCE.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> List of all breaches of unsecured PHI during the time period under review, including the date of discovery <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach.</p> <p style="text-align: right;">45 CFR §164.404(b) 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members Three examples of breach notification letters to members <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible:</p> <p>a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.</p> <p>b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).</p> <p>c. Any steps individuals should take to protect themselves from potential harm resulting from the breach.</p> <p>d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.</p> <p>e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(c)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Magellan did not have a reportable Breach during the review timeframe. • Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Magellan does not maintain a template for breach notification letters, as each letter is individualized to the specific incident. • All notifications are developed to include the required elements under 45 CFR Part 164, 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	Subpart D. In alignment with these requirements, our letters notify affected individuals, appropriately and are tailored to ensure it accurately reflects the facts of the incident while meeting all federal compliance standards.	
MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>18. The notification must be provided in the following form:</p> <ul style="list-style-type: none"> a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail. b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual. c. The notification may be provided in one or more mailings as information is available. <p style="text-align: right;">45 CFR §164.404(d)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Confirmation of first-class mailing <p>Evidence as Submitted by the MCE:</p> <p>Magellan did not have a reportable Breach during the review timeframe.</p> <ul style="list-style-type: none"> • Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		



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Required Actions: No action required.		
<p>19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided.</p> <p>a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means.</p> <p>b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must:</p> <p style="margin-left: 20px;">i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE’s website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.</p> <p style="margin-left: 20px;">ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn whether the individual’s unsecured PHI may be included in the breach.</p> <p>c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii).</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2)</p> <p>MCO Contract: HIPAA Business Associate Provisions</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 (pg.4,VII) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1).</p> <p style="text-align: right;">45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Magellan did not have an urgent incidents/reportable Breach during the review timeframe. • Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures 	<input checked="" type="checkbox"/> Met



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(a-b)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 	<input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary.</p> <p>a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site.</p> <p>b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members Annual notification to HHS of breaches of unsecured PHI, including the date of notification <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan did not have a reportable Breach during the review timeframe. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum-</p>	<ul style="list-style-type: none"> Policy Doc. - PR-BA Unauthorized Uses and Disclosures of Protected Health Information, PR-BA.1718.11 	
<p>MCE Description of Process: The processes and procedures on how the health plan upholds, maintains, uses and discloses protected health information for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach.</p> <p>a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of breaches of unsecured PHI reported by subcontractors One example of executed business associate agreement One example of executed subcontractor contract <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not have any subcontractors' relationships. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.</p> <p>c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach.</p> <p>d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.410 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>		
<p>MCE Description of Process: Magellan does not subcontract.</p>		
<p>HSAG Findings: The MCE reported it does not contract with any subcontracts; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
Notice of Privacy Practices		
<p>24. The MCE’s members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member’s rights and the MCE’s legal duties with respect to PHI.</p> <p>a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1).</p> <p>b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c).</p> <p style="text-align: right;">45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Process for disseminating Notice of Privacy Practices • Staff training materials • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the MCE’s website <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • N/A - This process was not delegated to LA CSOC. • Magellan is not classified as a Covered Entity and thus does not have a HIPAA Notice of Privacy Practices as outlined in 45 CFR §164.520(a)(1). The obligation was not contractually delegated to us by our Covered Entity Health Plan <p>Additional Documentation:</p> <ul style="list-style-type: none"> • https://www.magellanhealth.com/utilities/privacy-policy/ • Medicaid: Enrollee Rights and Responsibilities • PR-BA Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Healthcare Operations 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
MCE Description of Process: This process was not delegated to LA CSOC.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	23	X	1	=	23
	Not Met	=	0	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	23	Total Score	=		23
Total Score ÷ Total Applicable						=	100%



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Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	Required Components	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10. Evidence as submitted by the MCE: <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” Additional Documentation: <ul style="list-style-type: none"> Provisional POC FOC, Section II, Row 2 (pp.1) SVI.5_Pol_CSoC Treatment Record Reviews_2024 (previously submitted for Section V) SII R2 Treatment Record Review Tool_M R&R (Member Rights & Confidentiality sections) (previously submitted for Section II) <p>Explanation: The standardized FOC form is required for program participation and ensures the specific right is explained, understood, and agreed to by the member.</p> <p>The FOC form must be submitted as part of initial enrollment; if not completed within 30 calendar days, the youth will be disenrolled.</p> <p>Magellan’s TRR procedures ensure that completed forms are consistently included in member records. Policies and tools are tailored by provider type to address provider-specific requirements and maintain compliance.</p>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy. Evidence as submitted by the MCE: <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” Additional Documentation: <ul style="list-style-type: none"> QA audits to monitor care manager calls (described in virtual review) CSoC Treatment Record Reviews_2024 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220 MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. Evidence as submitted by the MCE: <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” Additional Documentation: <ul style="list-style-type: none"> Provisional POC FOC, Section V, Row 2 (pp. 2 - 4) SVI.5_Pol_CSoC Treatment Record Reviews_2024 (previously submitted for Section V) SII R2 Treatment Record Review Tool_M R&R (Member Rights & Confidentiality sections) (previously submitted for Section II) Explanation: The standardized FOC form is required for program participation and ensures the specific right is explained, understood, and agreed to by the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
	<p>The FOC form must be submitted as part of initial enrollment; if not completed within 30 calendar days, the youth will be disenrolled.</p> <p>Magellan’s TRR procedures ensure that completed forms are consistently included in member records. Policies and tools are tailored by provider type to address provider-specific requirements and maintain compliance.</p>	
<p>42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220</p> <p>MCO Contract: 2.9.32.1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6</p>	<p>4. Participate in decisions regarding his or her health care, including the right to refuse treatment.</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • (Handbook, Policy) • CSoC Member Handbook p. 24 “Member Bill of Rights” <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Provisional Plan of Care (POC) Freedom of Choice (FOC) form, Section II, Row 1 (pp. 1) • SVI.5_Pol_CSoC Treatment Record Reviews_2024 • SII R2 Treatment Record Review Tool_M R&R (Member Rights & Confidentiality sections) <p>Explanation: The standardized FOC form is required for program participation and ensures the specific right is explained, understood, and agreed to by the member.</p> <p>The FOC form must be submitted as part of initial enrollment; if not completed within 30 calendar days, the youth will be disenrolled.</p>	<p>Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>



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Standard II—Member Rights Checklist		
Reference	Required Components	
	Magellan’s TRR procedures ensure that completed forms are consistently included in member records. Policies and tools are tailored by provider type to address provider-specific requirements and maintain compliance.	
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. Evidence as submitted by the MCE: <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” Additional Documentation: <ul style="list-style-type: none"> Provisional Plan of Care (POC) Freedom of Choice (FOC) form, Section II, Row 3 (pp. 1) SVI.5_PoI_CSoC Treatment Record Reviews_2024 SII R2 Treatment Record Review Tool_M R&R (Restraints / Seclusions, Patient Safety, and Adverse Incident Sections) 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526 MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526. Evidence as submitted by the MCE: <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” Contract reference correction – 5.14.1.19 -The right of the member or his/her legal guardian to receive a copy of treatment records, including the right to request that the records be amended or corrected as allowed in 45 CFR Part 164. Policy # PR-BA.1705.08 PR-BA, Member Right to Request Access to Protected Health Information (PHI) Pg 2 Standard I 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9	<ul style="list-style-type: none"> Policy # PR-BA.1706.04-2024: PR-BA, Member Right to Request Amendment of Protected Health Information (PHI) Pg 2 Standard I Member Handbook, pg.26, Member Rights & Responsibilities, Member Bill of Rights, bullets 6 & 7. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provisional POC FOC, Section III, Row 1 (pp. 2) SVI.5_Pol_CSoC Treatment Record Reviews_2024 Member Right to Request Access to PHI - Request Form Member Right to Request Access to PHI - Denial Letter Member Right to Request Access to PHI - Appeal Denial Letter 	
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220 MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(c) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.15	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member. <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> (Handbook, Policy) CSoC Member Handbook p. 24 “Member Bill of Rights” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	<p>9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA)).</p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • MCD.105.03 -022024 - Medicaid: Integrity and Compliance Program, • Pages 6 and 7. Section D1. (i) (j)(k)(l)(o). • (Handbook, Policy) • CSoC Member Handbook p. 45 “Discrimination is Against the Law” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Member Information

Standard III—Member Information		
Requirement	Supporting Documentation	Score
Information Requirements		
<p>1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.</p> <p><i>“Readily accessible” means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.</i></p> <p><i>Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.</i></p> <p style="text-align: right;">42 CFR §438.10(c)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures Member materials, such as the member handbook, provider directory, member notices, etc. Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 1, CSOC Member Handbook, title, entire document CSoC Member Newsletter Fall/Winter 2024. Excerpts CSoC Member Newsletter Spring/Summer 2024.Excerpts Policy OP.MCD.338.08 Screenshot and explanation of website assessment tool 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process the health plan upholds to for providing member information in the formatting understood.</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>2. The MCE uses the definitions for managed care terminology developed by the State including:</p> <p>a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.</p> <p style="text-align: right;">42 CFR §438.10(c)(4)(i) 42 CFR §457.1207</p> <p>MCO Contract: Part 1, Glossary and Acronyms PAHP Contract: Part 7, Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures- (Documentation) Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSOC Member Handbook p. 42 “Dictionary,” Emergency Medical Condition, Emergency Services “What is an emergency??” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The identification through Magellan’s policy, CSOC Member Handbook for addressing an emergency/emergency medical condition.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>3. The MCE uses State-developed model member handbooks and member notices.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and Procedures Member materials, such as the member handbook Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 1, CSOC Member Handbook, title, entire document Member ABD Letters folder SIII R3 G&A Letters Policy -MR.MCD.404.09 -Medicaid: Enrollee Rights and Responsibilities (page 3, Readily Accessible) (Page 4, II, A-E) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Member ABD letters that were approved years ago by LDH are attached in the Member ABD Letters folder. These are letters used when a non-authorization is issued. There are 21 letter templates in the folder. Additionally, member notification templates for acknowledgment and resolution of appeals and grievances were also approved by LDH and are included in the folder.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Language and Format		
<p>4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider directory in English, including taglines 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>notices, and denial and termination notices, available in the prevalent non-English languages in its service areas.</p> <p>a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost.</p> <p>b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.</p> <p>c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services.</p> <p>d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE’s member/customer services unit.</p> <p>e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.</p> <p style="text-align: right;">42 CFR §438.10(d)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15</p>	<ul style="list-style-type: none"> • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials <p>Additional Documentation:</p> <ul style="list-style-type: none"> • CSoC Clinically Ineligible Letter • CSoC FFT Clinical Full Denial Letter • Corp Policy Tagline <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 47, p. 45 “Discrimination is Against the Law” • Member ABD Letters folder • Policy -MR.MCD.404.09 -Medicaid: Enrollee Rights and Responsibilities (pg. 5, G) 	<input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Section 1557 Language Access - COM.1952.01.P – Procedure CSoC Member Handbook, Spanish version & Vietnamese version 	
<p>MCE Description of Process: Member ABD letters that were approved years ago by LDH are attached in the Member ABD Letters folder. These are letters used when a non-authorization is issued. There are 21 letter templates in the folder.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE makes interpretation services available to each member free of charge.</p> <p>a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL).</p> <p>b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.</p> <p style="text-align: right;">42 CFR §438.10(d)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Executed interpretation services (oral and written) contract(s) Workflow for obtaining oral interpretation services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 3 “Dear member,” p. 16 “What if I am deaf or hard of hearing?” What if I speak a different language p. 45 “Discrimination is Against the Law”, Section- We provide free help and services to children and young people who have special behavioral health needs or disabilities, along with their families. We want you to be able to talk with us or write to us. We offer: Section 1557 Language Access - COM.1952.01.P – Procedure 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCE Description of Process: The process for how the health plan makes interpretation services available to each member written and orally.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>6. The MCE notifies members:</p> <ul style="list-style-type: none"> a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. <p style="text-align: right;">42 CFR §438.10(d)(5) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 16 “What if I speak a different language?” p. 16 “What if I have trouble with my vision?” p. 45 “Discrimination is Against the Law” • Section 1557 Language Access - COM.1952.01.P – Procedure 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The process for how the health plans, provides health plan notifications in interpretation services that are available to each member written and orally.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>7. The MCE provides all written materials for potential members and members consistent with the following:</p> <ul style="list-style-type: none"> a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member handbook • Provider directory- • All member newsletters during the time period of review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.</p> <p><i>“Limited English proficient (LEP)” means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.</i></p> <p style="text-align: right;">42 CFR §438.10(d)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3</p>	<ul style="list-style-type: none"> Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 1 CSOC Member Handbook, title, entire document Member ABD Letters folder Policy -MR.MCD.404.09 -Medicaid: Enrollee Rights and Responsibilities (Pg. 4, II,D) LA CSoC Voiance Report – Phone calls utilizing Language Assistance 	
<p>MCE Description of Process: Member ABD letters that were approved years ago by LDH are attached in the Member ABD Letters folder. These are letters used when a non-authorization is issued. There are 21 letter templates in the folder. The process for enrollee rights and responsibilities and reporting for calls through the health plans call center through utilizing of language assistance.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Information for Members		
<p>8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of:</p> <p style="margin-left: 20px;">a. Thirty calendar days prior to the effective date of the termination; or</p> <p style="margin-left: 20px;">b. Fifteen calendar days after receipt or issuance of the termination notice.</p> <p>PAHP:</p> <p style="margin-left: 20px;">a. The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.</p> <p style="text-align: right; margin-left: 20px;">42 CFR §438.10(f)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.9.2 PAHP Contract: 2.6.11.4 PIHP Contract: 5.14.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures- Workflow of provider termination process Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members- Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members- Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members- Tracking or reporting mechanism that demonstrates timeliness <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SIII R8 Member Inf Provider Term Policy Pages 4 and 8 SIII R8 Provider is Leaving the Network Procedure Full Document 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> SIII R8 Member Information MCE Initiated Term Ex1 SIII Member Information MCE Initiated Term Ex 2 SIII R8 Member Info Provider Initiated Term Future Date Ex 2 SIII R8 Member Information Provider initiated Future Term Date Ex 1 SIII R8 Provider Initiated Term Eff. Date Passed Ex 2 SIII RA Member Info LA OUTREACH Srvs Member Transition Tracking Provider is Leaving the Network/Contract Termination and Changes pg 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> In 2024, we only sent out 4 letters total to members for provider leaving the network. They are all attached. <ul style="list-style-type: none"> – Provider Term Letter to Member Guardian Example 1 – Provider Term Letter to Member Guardian Example 2 – Provider Term Letter to Member Guardian Example 3 – Provider Term Letter to Member Guardian Example 4 	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> SIII R8 Member Info Provider Initiated Term Eff. Date Passed EX1x 1 – Provider did not have members to transition. SIII R8 Member Info Provider Initiated Term Future Date Ex 2 SIII R8 Member Information MCE Initiated Term Ex 2 SIII R8 Member Information MCE Initiated Term Ex1 SIII R8 Member Information Provider initiated Future Term Date Ex 1 SIII R8 Provider is Leaving the Network Procedure Full Document Update Request Revised 	
<p>MCE Description of Process: The process the health plan upholds and maintains to for providing member information regarding provider termination that provided services specifically to specific members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of physician incentive plans Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the <i>MCE Description of Process</i>) 	<p><input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> List of physician incentive plans-This does not apply to Magellan. 	
MCE Description of Process: This does not apply to Magellan.		
HSAG Findings: The MCE did not have physician incentive plans; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Member Handbook		
10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE: <ol style="list-style-type: none"> Mails a printed copy of the information to the member’s mailing address; Provides the information by email after obtaining the member’s agreement to receive the information by email; Posts the information on the MCE’s website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or Provides the information by any other method that can reasonably be expected to result in the member receiving that information. 	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.) Member materials, such as member welcome packet-no- Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 3 “Dear CSoC Member” Provisional POC FOC pg 1 Policy -MR.MCD.404.09 -Medicaid: Enrollee Rights and Responsibilities (page 3, Readily Accessible) (Page 4, II, A-E) 	



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Requirement	Supporting Documentation	Score
<p>PAHP:</p> <p>a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled:</p> <p style="padding-left: 20px;">i. A current enrollee handbook</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.3 PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2 PIHP Contract: 5.8.3.3</p>	<ul style="list-style-type: none"> Acknowledgement Form and Welcome Letter Spreadsheet of Member Handbook Distribution 	
<p>MCE Description of Process: Magellan supplies the wraparound agencies with the member handbooks and when the wraparound agency meets with the guardian and the Freedom of Choice is signed, the guardian receives a member handbook and signs and dates the form saying they did.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The member handbook includes all requirements listed in the Member Handbook Checklist.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.10(g)(2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) Link to member handbook on MCE’s website HSAG will also use the results of the Member Handbook Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 1 CSOC Member Handbook, title, entire document 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Standard 111.11 Aux aids English Standard III.11 medication info in handbook III.11 aux Spanish version III.11 aux Vietnamese Version 	
MCE Description of Process: The CSoc Member Handbook, policy and procedure includes the requirements for the member checklist.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s member handbook did not include: <ul style="list-style-type: none"> Information in Spanish and Vietnamese regarding how to access auxiliary aids and services, including additional information in alternative formats or languages. Generic information on the treatment of behavioral health conditions and the principles of engagement, resilience, strength-based and evidence-based practice, and best/proven practices. Information on age of consent for behavioral health treatment. Additional information available upon request including information on the structure and operation of the MCE, pharmacy location or medication information availability, service utilization policies. 		
Required Actions: The MCE must include the following information in the member handbook: <ul style="list-style-type: none"> Information in Spanish and Vietnamese regarding how to access auxiliary aids and services, including additional information in alternative formats or languages. Generic information on the treatment of behavioral health conditions and the principles of engagement, resilience, strength-based and evidence-based practice, and best/proven practices. Information on age of consent for behavioral health treatment. Additional information available upon request including information on the structure and operation of the MCE, pharmacy location or medication information availability, service utilization policies. 		



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Requirement	Supporting Documentation	Score
<p>12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change.</p> <p><i>Note: LA defines significant as “important in effect or meaning.”</i></p> <p style="text-align: right;">42 CFR §438.10(g) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures- Workflow for member handbook changes One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the <i>MCE Description of Process</i>)- Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Policy -MR.MCD.404.09 -Medicaid: Enrollee Rights and Responsibilities Copy of Workflow Policy 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The process the health plan upholds to and maintains for changes to the member handbook and how that information is provided to the members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Provider Directory		
<p>13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist.</p> <p style="text-align: right;">42 CFR §438.10(h)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) Link to the online provider directory HSAG will also use the results of the Provider Directory Checklist <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SIII R13 Network Provider Data Maintenance pg 3 SIII R13 Member Info Printing Provider Directory SIII R13 Printed Provider Directory Sample Find a Provider Magellan of Louisiana <p>Additional Documentation:</p> <ul style="list-style-type: none"> LA CSoc Provider Directory This document was printed in 2023. A 2024 printed version is not available as the print function in the search tool is not functioning currently. IT is working on the issue. 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The process to address how the provider directory for Magellan is available via paper form, electronic form and the inclusion of the provider directory checklist.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan did not submit a printed version of the 2024 paper provider directory.</p> <p>Recommendations: HSAG recommends that the MCE ensure its public, searchable provider directory is updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p>Required Actions: The MCE must ensure it has the capability to make the provider directory available in paper form and ensure the paper provider directory includes required federal and State contract language.</p>		
<p>14. Information included in the MCE’s paper provider directory is updated at least:</p> <ul style="list-style-type: none"> a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCE has a mobile-enabled electronic provider directory. <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.</i> <p style="text-align: right;">42 CFR §438.10(h)(3)(i) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Three consecutive provider directory update examples, including the dates for when the updates were made <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SIII R14 Network Provider Data Maintenance pg 6 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how the provider directory for Magellan is updated and maintained.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>15. Information included in the MCE’s electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information.</p> <p>MCO:</p> <p>a. The web-based online version shall be updated in real time, but no less than weekly.</p> <p>PAHP:</p> <p>a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly.</p> <p style="text-align: right;">42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Workflow for updating the electronic provider directory • Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated provider information and the date the change was reflected in the electronic provider directory • Tracking mechanisms to demonstrate timeliness <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SIII R15 Network Provider Data Maintenance pg6 • SII R15 Member Info Provider Data Changes Ex. 1 • SII R15 Member Info Provider Data Changes Ex 2 • SII R15 Member Info Provider Data Changes Ex 3 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how the provider directory for Magellan is updated and maintained.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>16. The MCE’s provider directory is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right;">42 CFR §438.10(h)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the publicly available machine-readable provider directory on the MCE’s website <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SIII R16 Network Provider Data Maintenance pg3 • CreatePDF 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The process for how the provider directory for Magellan is maintained and located via the Magellan website, per requirement by Magellan’s state partner.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Formulary		
<p>17. The MCE makes available in electronic or paper form the following information about its formulary:</p> <p style="padding-left: 20px;">a. Which medications are covered (both generic and name brand).</p> <p style="padding-left: 20px;">b. What tier each medication is on.</p> <p style="text-align: right;">42 CFR §438.10(i)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the publicly available formulary on the MCE’s website <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: This does not apply to Magellan.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: Magellan did not utilize a drug formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>18. The MCE’s formulary drug list is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right;">42 CFR §438.10(i)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Confirmation of machine-readable formulary (e.g., .JSON format) • Link to the publicly available machine-readable formulary on the MCE’s website <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: This does not apply to Magellan.		
HSAG Findings: Magellan did not utilize a drug formulary; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Electronic Materials and Communications		
<p>19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following:</p> <ol style="list-style-type: none"> a. The format is readily accessible. b. The information is placed in a location on the MCE’s website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE’s homepage of its website • Tracking mechanisms related to requests for information in paper form that includes the date of the member’s request and the date it was provided to the member (e.g., mailed) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(c)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7</p>	<ul style="list-style-type: none"> Evidence for how members are informed that paper copies of information are available upon request and without charge <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> List of materials by electronics only Link provided Policies and Procedures Bill or Rights containing info on paper copies available <p>Additional Documentation:</p> <ul style="list-style-type: none"> Standard 111.19 Website evidence 	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard III—Member Information							
Total	Met	=	14	X	1	=	14
	Not Met	=	2	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	16	Total Score	=	14	

Total Score , Total Applicable	=	88%
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Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference-	Required Components	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE. Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 12-13 “What are the services for CSoC members?” p. 29-33 “What kind of behavioral health services can you get?” p. 33-34 “Coordinated System of Care (CSoC) Services” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State. Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 12 “How to Get Services” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided. Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 4 “Transportation” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE. Evidence as submitted by the MCE: <ul style="list-style-type: none"> There are no services. Magellan does not cover because of moral or religious objections. 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Reference-	Required Components	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> There are no services. Magellan does not cover because of moral or religious objections. 	
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. <i>For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 25 “Your right to information” 	
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member’s primary care provider. <i>The PIHP must also include procedures for plan of care development.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 8 “Welcome to Magellan of Louisiana” p. 13 “You can expect” p. 43-44 “Dictionary” 	
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 25 “Your right to information” p. 9 “Your Access to Behavioral Healthcare” 	



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42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 10 “What is an emergency?” p. 42 “Dictionary” 	
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 10 “How do I get help in an emergency?” 	
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 4 “Emergency” p. 10 “How do i get help in an emergency?” p. 11 “What if I have an emergency when I am away from home?” 	
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member’s freedom of choice among network providers.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Magellan does not have any restriction of freedom of choice. 	
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.10 PAHP Contract: 2.9.7.2 PIHP Contract: None	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider.	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	



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42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207 MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan).	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207 MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 24-28 “Member Rights and Responsibilities” 	
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member’s primary care provider/primacy dental provider.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 16 “How do I change providers?” 	
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	17. The right to file grievances and appeals.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 24 “Member Rights and Responsibilities” 	
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 18-19 “Grievances” p. 20-21 “Appeal and State Fair Hearing Procedures for Eligibility” p. 21 “How do you ask for an appeal?” 	



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42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	19. The availability of assistance in the filing process for grievances and appeals. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • CSoC Member Handbook p. 17 “What if I am not happy with the way I have been treated by Magellan or a Provider or with a decision made by Magellan about services?” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207 MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	20. The right to request a state fair hearing (SFH) (or a State external review for the Children’s Health Insurance Program [CHIP]) after the MCE has made a determination on a member’s appeal which is adverse to the member. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • CSoC Member Handbook p. 20 “Appeal and State Fair Hearing Procedures for Eligibility” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • CSoC Member Handbook p. 22 “How do you continue services during an eligibility appeal?” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3) MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) <i>The MCOs must provide a description of advance directives which includes:</i> <i>The MCO’s policies related to advance directives;</i> <i>The enrollee’s rights under State Law, including the to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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	<p><i>Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana’s Survey and Certification agency; and</i></p> <p><i>Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 26 “What is an advanced directive?” 	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5; 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. <i>For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.</i> <i>For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 9 “How can I get help through Magellan?” p. 16 “What if I speak a different language?” p. 16 “What if I have trouble with my vision?” 	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 9 “How can I get help through Magellan?” p. 27 “What to do about fraud and abuse” 	
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 25 “Your responsibilities as a member” p. 27 “What to do about fraud and abuse” 	



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42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. <i>The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	27. <i>The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. <i>The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.28 PAHP Contract: NA PIHP Contract: NA	29. <i>The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	30. <i>The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. <i>The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. <i>The MCOs must include the date of the last revision;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	33. <i>The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:</i> <ol style="list-style-type: none"> a. <i>A description of covered behavioral health services;</i> b. <i>Where and how to access behavioral health services and behavioral health providers;</i> c. <i>General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices;</i> d. <i>Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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	<p>e. <i>Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	<p>34. <i>The PIHP must include CSoC eligibility requirements;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 12 “How do I find out if I qualify for CSoC services?” p. 13 “You can expect.” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	<p>35. <i>The PIHP must include Member’s Bill of Rights;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 24 “Member Bill of Rights” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	<p>36. <i>The PIHP must include where to find medical necessity criteria on the Contractor’s website and how to request hardcopies of medical necessity criteria;</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook, pg. 22, “How will I know the appeal decision”. 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	<p>37. <i>The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a “no-show;”</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 15 “How do I make, change, and cancel appointments?” 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. <i>The PIHP must include family’s/caregiver’s or legal guardian’s role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 15 “Welcome to Magellan of Louisiana” p. 13 “You can expect” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. <i>The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult’s engagement, resilience, strength-based and evidence-based practice, and best/proven practices;</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 29 “More Information about the Behavioral Health Care Services Offered” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. <i>The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 34-35 “Medical Services” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. <i>The PIHP must include any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment;</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 23 “Privacy Policies”, sections 1-6 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. <i>The PIHP must include how to identify and contact the WAAs and FSO;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 40-41 “Coordinated System of Care – Family Support Organization” and “Coordinated System of Care Wraparound Agencies” 	



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42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. <i>The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 9 “Magellan can help you find providers who speak your language and get written material in your language.” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. <i>The PIHP must include the date of the last revision;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 1 “Title Page” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. <i>The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 17 “What if I am still not sure how to get services?” 	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. <i>The PIHP must include additional information that is available upon request, including the following:</i> <ol style="list-style-type: none"> a. <i>Information on the structure and operation of the Contractor;</i> b. <i>Pharmacy location or medication information availability;</i> c. <i>Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and</i> d. <i>Service utilization policies</i> 	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 4 “More information” 	



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Provider Directory Checklist

Standard II—Provider Directory Checklist		
Reference	Required Components	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider’s name as well as any group affiliation.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: SII PD Checklist R1 Provider Name and Group Affil	
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • SII PD Checklist R2 Street address 	
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • SII PD Checklist R3 Provider Telephone Number 	
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207	4. Website Uniform Resource Locator (URL), as appropriate.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • SII PD Checklist R4 URL 	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1		
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> SII PD Checklist R5 Specialties 	
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> SII PD Checklist R6 Accepting New Patients 	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	7. The provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> SII PD Checklist R7 Languages 	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider’s office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. Evidence as submitted by the MCE: <ul style="list-style-type: none"> • SII PD Checklist R8 Wheelchair Accessible 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: <ol style="list-style-type: none"> a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; The MCO provider directory components are included for the following provider types <i>and shall be delineated by parish and zip code</i> : <ol style="list-style-type: none"> a. <i>Hospital primary care physician (PCP) groups</i> b. <i>Clinic settings</i> c. <i>Home and community-based services</i> d. <i>Outpatient therapy</i> e. <i>Residential substance use</i> f. <i>Youth residential services</i> g. <i>Inpatient mental health and residential substance use services</i> h. <i>Federally qualified health centers (FQHCs)</i> i. <i>Rural health clinics (RHCs)</i> j. <i>Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.</i> k. <i>Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.</i> l. <i>Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.</i> 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Provider Directory Checklist		
Reference	Required Components	
	<p>The PAHP provider directory components are included for the following provider types:</p> <ul style="list-style-type: none"> a. <i>Endodontists</i> b. <i>Maxillofacial surgeons</i> c. <i>Oral surgeons</i> d. <i>Orthodontists</i> e. <i>Pedodontists</i> f. <i>Periodontists</i> g. <i>Prosthodontists</i> h. <i>Special needs pedodontists</i> 	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	<p>10. <i>The PAHP provider directory must include the following:</i></p> <ul style="list-style-type: none"> a. <i>The provider’s cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;</i> b. <i>Office hours;</i> c. <i>Specific performance indicators;</i> d. <i>A statement that some providers may choose not to perform certain services based on religious or moral beliefs;</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	<p>11. <i>The PAHP Provider Directory must also include the following:</i></p> <ul style="list-style-type: none"> a. <i>Providers arranged by name in alphabetical order</i> b. <i>Showing the provider’s specialty,</i> c. <i>Providers listed by specialty in alphabetical order by name.</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. <i>The PIHP Provider Directory must include the following:</i> <ol style="list-style-type: none"> a. <i>Indication of populations served by the provider (e.g., age range of clients) and specialties;</i> b. <i>Identification of any restrictions on the member’s freedom of choice among providers;</i> c. <i>Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours);</i> d. <i>Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.</i> 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • SII PD Checklist R12 	



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Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
Definitions		
<p>1. The MCE defines “emergency medical condition” as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ol style="list-style-type: none"> a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1, Glossary and Acronyms PAHP Contract: Part 7, Glossary and Acronyms PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 42 “Dictionary” • SR IV ER and Post Stab LA Magellan Prov MCD Addendum 1,2,3 • S IV ER and Post Stab. Magellan Provider Agreement 1, 2, 3 • CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE defines “emergency services” as covered inpatient and outpatient services that are as follows:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>a. Furnished by a provider that is qualified to furnish these services under Title 42.</p> <p>b. Needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1, Glossary and Acronyms PAHP Contract: Part 7, Glossary and Acronyms PIHP Contract: Glossary</p>	<ul style="list-style-type: none"> Provider materials, such as the provider manual- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 42 “Dictionary”, “Emergency Services”. CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg. 4.II, D) 	<p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE defines “poststabilization care services” as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p> <p style="text-align: right;">42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: Part 1, Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SR IV ER and Post Stab LA Magellan Prov MCD Addendum 1,2,3 S IV ER and Post Stab. Magellan Provider Agreement 1, 2, 3 CSoC Member Handbook p. 43 “Dictionary”, “Post-stabilization Care Services” CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg. 4.II, D) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services-potabilization care of services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Coverage and Payment		
<p>4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE.</p> <p style="text-align: right;">42 CFR §438.114(c)(1)(i) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual- • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services- • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 10 “How do I get help in an emergency?” • S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 • SRIV ER and Post Stab R4 ER Services • SIV R4 Claim Examples ER Paid Claims • CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg. 4.II, D) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>5. The MCE does not deny payment for treatment obtained under either of the following circumstances:</p> <p>a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of “emergency medical condition.”</p> <p>b. A representative of the MCE instructs the member to seek emergency services.</p> <p style="text-align: right;">42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services- • Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)- <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 • Accessibility of Service and Care Policy pg 3 • CSoC Member Handbook p. 10 &11 “How do I get help in an emergency?” • CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Accessibility of Service and Care CO.204.13 2024 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Tracking when a representative instructs member to seek emergency services is explained in the Accessibility of Service and Care Policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Additional Rules for Emergency Services		
<p>6. The MCE does not:</p> <p style="margin-left: 20px;">a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.</p> <p style="margin-left: 20px;">b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the MCE, or applicable State entity of the member’s screening and treatment within 10 calendar days of presentation for emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(d)(1) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual Claim payment algorithm for emergency services Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 CSoC Member Handbook p. 10 “How do I get help in an emergency?” CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>7. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.</p> <p style="text-align: right;">42 CFR §438.114(d)(2) 42 CFR §457.1228</p> <p>MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual- • Claim payment algorithm for emergency and poststabilization services • Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) - <hr/> <p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 • CSoC Member Handbook p. 10 “How do I get help in an emergency?” • CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE.</p> <p style="text-align: right;">42 CFR §438.114(d)(3)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA</p>	<p style="text-align: right;">42 CFR §457.1228</p> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 This does not apply to Magellan. CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg. 4.H) Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services. Magellan has not had any providers reach out for peer to peer discussion, and in-turn has not completed any case examples.. 	
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Coverage and Payment of Poststabilization Care Services		
<p>9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative.</p>	<p style="text-align: right;">42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual Workflow for claims review process for post stabilization services- Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1</p>		



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Requirement	Supporting Documentation	Score
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 • CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg 5, A, B, & C) • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) Magellan has not had any providers reach out for peer to peer discussion, and in-turn has not completed any case examples. 	
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members and also the financial coverage for payment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member’s stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1	<ul style="list-style-type: none"> CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg 5, A, B, & C) 	
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members and also the financial coverage for payment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member’s stabilized condition if:</p> <ol style="list-style-type: none"> The MCE does not respond to a request for pre-approval within one hour. The MCE cannot be contacted. The MCE representative and the treating physician cannot reach an agreement concerning the member’s care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met. <p style="text-align: right;">42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual Workflow for claims review process for poststabilization services Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE’s response. One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 Initial Inpatient Psychiatric Review Procedure pg 3 CM02 WY2 Q3 Auth Timeliness CM02 WY2 Q4 Auth Timeliness CM02 WY3 Q1 Auth Timeliness 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1	<ul style="list-style-type: none"> CM02 WY3 Q2 Auth Timeliness CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg 5, A, B, & C) One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services Magellan has not had any providers reach out for peer to peer discussion, and in-turn has not completed any case examples. 	
<p>MCE Description of Process: The process of tracking in our EHR when an inpatient authorization request comes in and when a decision is made is in the Initial Inpatient Psychiatric Review Procedure. Also included are the 2024 quarterly reports showing authorization timeliness that are given to LDH each quarter.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Workflow for claims review process for poststabilization services Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> CSoC Member Handbook p. 10 “How do I get help in an emergency?” CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg 5, A, B, & C) Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) Magellan has not had any providers reach out for peer to peer discussion, and in-turn has not completed any case examples. 	
<p>MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members and also the financial coverage for payment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
End of the MCE’s Financial Responsibility		
<p>13. The MCE’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ol style="list-style-type: none"> A plan physician with privileges at the treating hospital assumes responsibility for the member’s care. A plan physician assumes responsibility for the member’s care through transfer. An MCE representative and the treating physician reach an agreement concerning the member’s care. The member is discharged. <p style="text-align: right;">42 CFR §422.113(c)(3)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> S IV ER And Post-Stabilization Services # 4, 5, 6, 7, 8, 9, 10 CO.MCD.251.02 - Medicaid: Emergency Services and Post-Stabilization Services (Pg 5, C) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<div style="text-align: right; margin-bottom: 5px;">42 CFR §438.114(e)</div> <div style="text-align: right; margin-bottom: 5px;">42 CFR §457.1228</div> MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1		
MCE Description of Process: The process for how Magellan identifies, upholds and maintains emergency medical services for members and also the financial coverage for payment.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IV—Emergency and Poststabilization Services							
Total	Met	=	13	X	1	=	13
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	13	Total Score		=	13

Total Score ÷ Total Applicable	=	100%
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Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
Delivery Network		
<p>1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(b)(1) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Network Development and Management Plan pages 5-7, 17-21, 33-37, 69-99, 109, and 173 • CSoC Provider Handbook, Member Access to Care, pages 21-22 • CSoC Provider Handbook, Cultural Competency, pages 18-19 • Minnie Joyce Crawford Individual Agreement • Minnie Joyce Crawford Individual LA CSoC Addendum • Maries Family Healthcare & Sitter Service Organizational Agreement • Maries Family Healthcare & Sitter Services Organizational LA CSoC Addendum 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Sheila Bolfa PMHNP BC LLC Group Agreement Sheila Bolfa PMHNP BC LLC Group Addendum Louisiana Behavioral Health Hospital LA CSoc Agreement Louisiana Behavioral Health Hospital LA CSoc Addendum Compass Behavioral Health Services MHR Agreement Compass Behavioral Health Services MHR LA CSoc Addendum Network Organizational Provider Assessment - CR.1117.04 - Policy, Pages 2 & 3 Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Pages 2 & 7 <p>Additional Documentation:</p> <ul style="list-style-type: none"> CSoc_Network Development and Management Final 2025 	
<p>MCE Description of Process: The annual Network Development Plan serves as the primary source of validation for our compliance with network adequacy requirements. It includes a comprehensive evaluation of the provider network, including provider type, specialty, and service availability across all regions. The plan details how the network meets access standards for all members, including individuals with limited English proficiency and those with physical or mental disabilities. It also confirms that provider participation is supported by written agreements and that ongoing monitoring is conducted to ensure the network remains sufficient to deliver all covered services as required under the contract.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>2. The MCE provides female members with direct access to a women’s health specialist within the provider network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health specialist.</p> <p style="text-align: right;">42 CFR §438.206(b)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Coverage/authorization guidelines <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: This does not apply to Magellan.		
HSAG Findings: Family planning services are not applicable to the PIHP; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p> <p style="text-align: right;">42 CFR §438.206(b)(7) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook List of provider types designated as family planning providers Network adequacy analysis of family planning providers <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: This does not apply to Magellan.		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: Family planning services are not applicable to the PIHP; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
<p>4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.</p> <p style="text-align: right;">42 CFR §438.206(b)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.13.6.2.32 PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5 PIHP Contract:7.2.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis. • Coverage/authorization guidelines <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoc Member Handbook p. 17 “How do I get a second opinion?” • CSoc Provider Handbook, Initiating Care-Page 23, 25-26, Concurrent Review- pages 25-26 • Second opinion tracking/analysis. Magellan does not have a second opinion tracking analysis. • Ad hoc Provider Authorization and Referral Policy page 3 • Medicaid Enrollee Rights and Responsibilities page 1 • Changes to Pass Through Services Limits and Psychological Testing • New Provider Orientation, slides 1, 16, 19, 20, 21, 22, 31, 63, 73 (4th and 5th sections) 91 and 92 (1st section) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: While a standalone second opinion tracking or analysis report is not maintained, compliance with this requirement is supported through multiple source documents. These include member rights materials, provider manuals, call center scripts, and care management protocols, all of which outline the process for obtaining a second opinion from a network provider or, if unavailable, from a non-network provider at no cost to the member. These documents collectively demonstrate our operational procedures and member communications that ensure access to second opinions in accordance with contractual requirements. If the youth/guardian requests a second opinion, it will be arranged for them at no cost. There have not been any requests for a second opinion, so there is nothing to report on.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element. Recommendations: HSAG recommends that Magellan develop a tracking mechanism for second opinions for future use.</p>		
<p>Required Actions: Magellan did not have any requests for second opinions during this audit period.</p>		
<p>5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them.</p> <p style="text-align: right;">42 CFR §438.206(b)(4) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 16 “How can I find help when the providers don’t offer the services I need?” • Ad Hoc Provider Authorization and Referral - NE.1304.09 - Policy • Minnie Joyce Crawford Single Case Agreement, Ashley Salone with Tranquil Solutions Group Single Case Agreement, and Compass Behavioral Center of Crowley Single Case Agreement 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> CSoC Network Development and Management Plan pages 61, 64-66 Ad Hoc Agreement Procedure Pages 1-3 	
<p>MCE Description of Process: We maintain a policy and process for executing ad hoc provider agreements to ensure timely access to necessary services when an in-network provider is not available. This includes verifying that the out-of-network provider is in good standing, consistent with the credentialing and quality standards applied to our in-network providers. When such situations arise, services are covered at no additional cost to the member and remain covered out-of-network for as long as the in-network network is unable to provide the required services. This approach ensures timely and adequate access to medically necessary services in accordance with contractual obligations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p style="text-align: right;">42 CFR §438.206(b)(5) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Claims processing guidelines Member materials, such as the member handbook Provider materials, such as materials on the MCE’s website Three examples of executed single case agreements <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 16 “How can I find help when the providers don’t offer the services I need?” CSoC Provider Handbook <ul style="list-style-type: none"> Submission of Claims, pages 61-62 Claims Disputes, pages 63-64 NPI Numbers, pages 65-66 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Minnie Joyce Crawford Single Case Agreement, Ashley Salone with Tranquil Solutions Group Single Case Agreement, and Compass Behavioral Center of Crowley Single Case Agreement • CSoC Network Development and Management Plan pages 64-66 Ad Hoc Provider Authorization and Referral - NE.1304.09 - Policy • Magellan CSoC BH OON OOSP Report January 2024 • Magellan CSoC BH OON OOSP Report February 2024 • Magellan CSoC BH OON OOSP Report March 2024 • Magellan CSoC BH OON OOSP Report April 2024 • Magellan CSoC BH OON OOSP Report May 2024 • Magellan CSoC BH OON OOSP Report June 2024 • Magellan CSoC BH OON OOSP Report July 2024 • Magellan CSoC BH OON OOSP Report August 2024 • Magellan CSoC BH OON OOSP Report September 2024 • Magellan CSoC BH OON OOSP Report – October 2024 	



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Magellan CSoC BH OON OOSP Report November 2024 Magellan CSoC BH OON OOSP Report December 2024 	
<p>MCE Description of Process: We maintain a policy and process for executing ad hoc provider agreements to ensure timely access to necessary services when an in-network provider is not available. This includes verifying that the out-of-network provider is in good standing, consistent with the credentialing and quality standards applied to our in-network providers. When such situations arise, services are covered at no additional cost to the member and remain covered out-of-network for as long as the in-network network is unable to provide the required services. This approach ensures timely and adequate access to medically necessary services in accordance with contractual obligations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element.</p>		
<p>Required Actions: No action required.</p>		
<p><i>42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]</i></p>		
Timely Access		
<p>7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Network analysis (e.g., appointment standards) - HSAG will also use the results of the Access Standards: Appointment Times Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Network Development and Management Plan pages 61-63 Network Appointment Availability WY3 Q2 2025 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Network Appointment Availability WY3 Q1 2025 Network Appointment Availability WY2 Q4 2024 Network Appointment Availability WY2 Q3 2024 CSoC Provider Handbook, Member Access to Care, pages 21-22 Network Provider Agreement page 4 Network Provider Addendum, page 4 LA CSOC_Network Monitoring Ongoing Review Process, Page 8 	
<p>MCE Description of Process: Magellan complies with and requires its network providers to adhere to State standards for timely access to care and services, taking into account the urgency of the member’s needs. These standards are outlined in the Access Standards: Appointment Times Checklist, which defines required timeframes for routine, urgent, and emergency services.</p> <p>Magellan communicates these requirements to providers through the provider agreement and provider manual. To ensure compliance, we conduct ongoing monitoring through secret shopper calls, provider self-attestations, and periodic audits. Identified deficiencies are addressed through corrective action plans and technical assistance. Outcomes of these monitoring activities, along with any remediation efforts, are reported to the State and included in the Magellan’s annual network development and compliance plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements of this element. While Magellan's quarterly secret shopper audits demonstrated appointment time compliance, Magellan's Network Appointment Availability WY2 Q2 2025 report showed that 8 percent, or 1 out of 13 providers, demonstrated non-compliance with the network monitoring appointment times policy metric, which was defined and chosen by Magellan. Refer to the Access Standards: Time/Distance Checklist for specific areas of noncompliance.</p>		
<p>Required Actions: The MCE must ensure its network providers meet the State standards for timely access to care and services, taking into account the urgency of the need for services, including any appointment time metrics defined and chosen by Magellan. Refer to the Access Standards: Time/Distance Checklist for specific areas of noncompliance.</p>		



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Requirement	Supporting Documentation	Score
<p>8. MCO: The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members.</p> <p>PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Audit or secret shopper results/reports <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: This does not apply to Magellan.</p>		
<p>HSAG Findings: During the interview, Magellan stated that it renders services in members’ homes and in the community; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
<p>9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Results of provider monitoring mechanisms Audit or secret shopper results/reports <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Accessibility of Service and Care Policy pg 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> CSoC Network Development and Management Final 2025 CSoC Provider Handbook SV R9 Magellan Network Provider Agreement SV R9 MHS Organization Site Review - LA SV R9 Documents noted in 2 and 3 monitor for compliance with emergent, urgent and routine appointments. These tools are used for the 24X7 requirement. 	
MCE Description of Process: The required provider related documents do not address this standard 5.11.6. This standard applies to the MCE call center staff and timeframes of availability.		
HSAG Findings: HSAG has determined that the MCE met the requirements of this element.		
Required Actions: No action required.		
10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. <ol style="list-style-type: none"> The MCE monitors network providers regularly to determine compliance. The MCE takes corrective action if there is a failure to comply by a network provider. <p style="text-align: right;">42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1</p>	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Results of provider monitoring mechanisms Audit or secret shopper results/reports Three examples of corrective action taken when a provider fails to meet timely access standards 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Network Appointment Availability WY3 Q2 2025 Network Appointment Availability WY3Q1 2025 Network Appointment Availability WY2 Q4 2024 	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Network Appointment Availability WY2 Q3 2024 CSoC Provider Handbook <ul style="list-style-type: none"> – Member Access to Care pages 21-22 – Network Monitoring, pages 59-60 Provider Network Ongoing Monitoring - NE.1318.07 - Policy CSoC Network Development and Management Plan, pages 6 (Network Monitoring), 78 (Tables 15 and 16) 	
<p>MCE Description of Process: We ensure compliance with timely access to care and service standards through a combination of secret shopper call activities and ongoing provider monitoring. These mechanisms allow us to regularly assess provider availability and appointment access. Results are reported to the state and are also incorporated into our annual Network Development Plan, which details compliance outcomes, identified deficiencies, and any resulting remedial actions or interventions. When noncompliance is identified, we take corrective action with the provider to address and resolve the issue in alignment with contractual requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element.</p>		
<p>Required Actions: No action required.</p>		
Access and Cultural Considerations		
<p>11. The MCE participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.</p> <p style="text-align: right;">42 CFR §438.206(c)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.4.1.11</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider materials, such as the provider manual and provider contract Cultural competency plan Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
PAHP Contract: 2.1.2 PIHP Contract: 5.1.8	<ul style="list-style-type: none"> Analysis of provider network linguistic capabilities Analysis of provider network cultural competence <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoc Provider Handbook, Cultural Competency, pages 18-19 CSoc Network Development and Management Plan, pages 8-23, 40-41, and pages 55 (Begin Individualized Plan of Care to Youth & Family's Culture, Preferences, Strengths, & Needs) - 60 Dropdown Titles and the Selections Available, pages 2-3 Semi Annual Reports Cultural Competency May 2024 Semi Annual Reports Cultural Competency May 2025 Semi Annual Reports Cultural Competency November 2024 Provider Search Directory Annual Provider Training Plan 2024, pages 4-6, and 9 LA CSOC_Network Monitoring Ongoing Review 	
<p>MCE Description of Process: To support this effort to promote the delivery of services in a culturally competent manner, we require staff of all contracted agencies to complete annual cultural competency training. We monitor the providers and staff compliance with this requirement and report the results to the State. In addition, outcomes of this monitoring—including compliance rates, identified deficiencies, and any required remediation—are documented in our annual Network Development Plan. These efforts help ensure services are delivered appropriately</p>		



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Requirement	Supporting Documentation	Score
to members of diverse cultural and ethnic backgrounds, those with limited English proficiency, individuals with disabilities, and all members regardless of sex.		
HSAG Findings: HSAG has determined that the MCE met the requirements of this element.		
Required Actions: No action required.		
Accessibility Considerations		
<p>12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(c)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers’ accessibility • Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoc Network Development and Management Plan, pages 33-37, 74-75 and page 76 (3rd paragraph) • Site Review, Section VII Safety and Physical Plant 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Information about the website, page 2 Provider Directory Screenprint Network Provider Data Maintenance and Data Integrity - NE.1325.05-2024 – Policy <p>Additional Documentation:</p> <ul style="list-style-type: none"> Site Visit 601650443 COMPASS BHVRL HLTH SVCS SV 5 R12 Magellan only had one provider join the network in 2024 that required a site review for ADA compliance. Three providers joined the network for respite services which are done in the home and community and ADA accessibility for members is not required. 	
<p>MCE Description of Process: To ensure that network providers offer physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities, we conduct site reviews at the time of contracting. We also monitor ongoing provider compliance with maintaining accurate and up-to-date practice information, including details related to accessibility accommodations. This information is made available to members through our online provider directory. These monitoring efforts, along with any identified gaps and corrective actions, are documented in our annual Network Development Plan</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements of this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Basic Rule		
<p>13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).</p> <p>a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:</p> <p style="margin-left: 20px;">i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and supports (LTSS) that is adequate for the anticipated number of members for the service area.</p> <p style="margin-left: 20px;">ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p> <p>PIHP</p> <p>a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population).</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Network adequacy reports/analyses • Exceptions approved by the State • HSAG will also use the results of the Access Standards: Time/Distance Checklist • HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Gap Analysis WY3 Q2 2025 • Gap Analysis WY3 Q1 2025 • Gap Analysis WY2 Q4 • Gap Analysis WY2 Q3 • LA_CSoc - Quarterly_Prescribers_Geo WY 2 Q3 • LA_CSoc - Quarterly_Psychiatrists_Geo WY2 Q3 • LA_CSoc - Quarterly_OP_Services_Geo WY2 Q3 • LA_CSoc - Quarterly_BH_Specialists_Geo WY 2 Q3 • LA_CSoc - Psychiatrists_Geo WY3 Q2 2025 • LA_CSoc - Psychiatrists_Geo WY3 Q1 2025 • LA_CSoc - Psychiatrists_Geo WY2 Q4 • LA_CSoc - Prescribers_Geo WY3 Q2 2025 • LA_CSoc - Prescribers_Geo WY3 Q1 2025 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2	<ul style="list-style-type: none"> LA_CSoc - Prescribers_Geo WY2 Q4 LA_CSoc - OP_Services_Geo WY3 Q2 2025 LA_CSoc - OP_Services_Geo WY3 Q1 2025 LA_CSoc - OP_Services_Geo WY2 Q4 LA_CSoc - BH_Specialists_Geo WY3 Q2 2025 LA_CSoc - BH_Specialists_Geo WY3 Q1 2025 LA_CSoc - BH_Specialists_Geo WY2 Q4 Network Appointment Availability WY3 Q2 2025, Measure 2, & 3 page 1 and Indicator 2 & 3 pages 2-3 Network Appointment Availability WY3Q1 2025, Measure 2, & 3 page 1 and Indicator 2 & 3 pages 2-3 Network Appointment Availability WY2 Q4 2024, Measure 2, & 3 page 1 and Indicator 2 & 3 pages 2-3 Network Appointment Availability WY2 Q3 2024, Measure 2, & 3 page 1 and Indicator 2 & 3 pages 2-3 	
<p>MCE Description of Process: The quarterly gap analysis conducted by our team addresses Geographic (GEO) Access deficiencies and serves as the supporting documentation for this request. This analysis is used to assess and ensure adequate network capacity as defined by the contractual GEO Access Standards and applicable service requirements. We submit this as our attestation based on the findings and ongoing monitoring provided through this analysis.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements of this element. Magellan’s Network Adequacy Reports and Quarterly Gap Analyses demonstrated Magellan’s commitment to meet access to care standards. Magellan’s Time/Distance Checklist was used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified.</p>		



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Requirement	Supporting Documentation	Score
<p>Required Actions: The MCE must offer an appropriate range of services that are adequate for the anticipated number of members for the service area and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Refer to the Access Standards: Time/Distance Checklist for specific areas of noncompliance.</p>		
Timing		
<p>14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following:</p> <ol style="list-style-type: none"> a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the MCE’s operations that would affect the adequacy of capacity in services, including: <ol style="list-style-type: none"> i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. <p style="text-align: right;">42 CFR §438.207(c) 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoc Network Development and Management Plan, page 100 (Material Changes to Network) <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Gap Analysis WY2 Q3 • Gap Analysis WY2 Q4 • Gap Analysis WY3 Q1 2025 • Gap Analysis WY3 Q2 2025 • LA_CSoc - BH_Specialists_Geo WY2 Q4 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: The network’s annual Network Development Plan is a comprehensive document that includes detailed analyses of both the provider network and member enrollment. It outlines membership trends, service needs, provider accessibility by type, specialty, and rendered service. The plan also evaluates compliance with access and availability standards, identifies geographic access gaps, and documents the interventions implemented, outcomes achieved, and any material changes to the network.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements of this element.		
Required Actions: No action required.		
Exceptions Process		
<p>15. To the extent the State permits an exception to any of the provider-specific network standards, MCO: a. <i>The MCO must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.</i></p> <p>PAHP: a. <i>Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.</i></p> <p>PIHP: a. <i>Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.</i></p> <p style="text-align: right;">42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Gap Analysis WY3 Q2 2025 • Gap Analysis WY3 Q1 2025 • Gap Analysis WY2 Q4 • Gap Analysis WY2 Q3 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCE Description of Process: Not applicable, no exceptions		
HSAG Findings: Family planning services are not applicable to the PIHP; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	9	X	1	=	9
	Not Met	=	2	X	0	=	0
	Not Applicable	=	4				
Total Applicable		=	11	Total Score		=	9

Total Score ÷ Total Applicable	=	82%
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Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
Primary Care Physician Access Standards		
42 CFR §438.206(c)(1)(I) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. <i>MCO:</i> a. <i>PCP appointments are available as follows:</i> i. <i>Non-urgent sick primary care: 72 hours</i> ii. <i>Non-urgent routine primary care: 6 weeks</i> <i>PAHP:</i> a. <i>Primary dental care: within 30 days</i> b. <i>Follow-up dental services: within 30 days after assessment</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. <i>MCO:</i> a. <i>For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide:</i> b. <i>Specialist appointments: one month</i> c. <i>Non-urgent routine behavioral health care: 14 days</i> d. <i>Urgent non-emergency behavioral health care: 48 hours</i> e. <i>ASAM Level 3.3, 3.5, and 3.7: 10 business days</i> f. <i>Residential withdrawal management: 24 hours when medically necessary</i> g. <i>Psychiatric Residential Treatment Facility (PRTF): 20 calendar days</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows: <ul style="list-style-type: none"> i. Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; ii. Primary dental care: within 30 days iii. Follow-up dental services: within 30 days after assessment <p><i>PIHP:</i></p> <ul style="list-style-type: none"> a. Urgent non-emergency behavioral health care: 48 hours 	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	
Hospital and Emergency Services Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1</p>	<p>3. <i>MCO:</i></p> <ul style="list-style-type: none"> a. Emergency care: 24 hours, 7 days/week within one hour of request b. Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request c. After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes <p><i>PAHP:</i></p> <ul style="list-style-type: none"> a. Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization; <p><i>PIHP:</i></p> <ul style="list-style-type: none"> a. Emergent care: 24 hours, 7 days/week within one hour of request b. Emergent, crisis or emergency services must be available at all times. c. Urgent care: 24 hours, 7 days/week within 48 hours of request 	<p>Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> Accessibility of Service and Care Policy pg. 3 Network Appointment Availability WY3 Q2 2025 Network Appointment Availability WY3Q1 2025 Network Appointment Availability WY2 Q4 2024 Network Appointment Availability WY2 Q3 2024 CSoC_Network Development and Management Plan Access Standard Checklist CSoC Provider Handbook, Member Access to Care, pages 21-22 	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. <i>MCO:</i> a. <i>OB/GYN care for pregnant women:</i> i. <i>1st trimester: 14 days</i> ii. <i>2nd trimester: 7 days</i> iii. <i>3rd trimester: 3 days</i> iv. <i>High risk pregnancy, any trimester: 3 days</i> b. <i>Family planning appointments: 1 week</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: None PAHP Contract: None PIHP Contract: None	5. <i>MCO:</i> <i>PAHP:</i> <i>PIHP:</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	



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Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<p>1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i></p> <p>2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: None PAHP Contract: None PIHP Contract: None	<p>3. <i>Acute Inpatient Hospitals</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<p>4. <i>Laboratory</i></p> <p>5. <i>Radiology</i></p> <p>6. <i>Pharmacy</i></p> <p>7. <i>Hemodialysis Centers</i></p> <p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. <i>OB/GYN: 1:10,000</i> 9. <i>Allergy/Immunology: 1:100,000</i> 10. <i>Cardiology: 1:20,000</i> 11. <i>Dermatology: 1:40,000</i> 12. <i>Endocrinology and Metabolism: 1:25,000</i> 13. <i>Gastroenterology: 1:30,000</i> 14. <i>Hematology/Oncology: 1:80,000</i> 15. <i>Nephrology: 1:50,000</i> 16. <i>Neurology: 1:35,000</i> 17. <i>Ophthalmology: 1:20,000</i> 18. <i>Orthopedics: 1:15,000</i> 19. <i>Otorhinolaryngology/Otolaryngology: 1:30,000</i> 20. <i>Urology: 1:30,000</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	21. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	22. <i>Adult Physician Extenders: 1:1,000</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	



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Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	23. Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	24. Pediatric Physician Extenders: 1: 1,000	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	



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Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Primary Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: 2.6.2.6.1 PIHP Contract: None	<ol style="list-style-type: none"> 1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 3. <i>Primary Dental Services:</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles one-way</i> b. <i>Urban Parishes: 10 miles</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	
Hospitals		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<ol style="list-style-type: none"> 4. <i>Acute Inpatient Hospitals</i> <ol style="list-style-type: none"> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 10 miles</i> 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> • This does not apply to Magellan. 	



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Ancillary		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	5. <i>Laboratory:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i> 6. <i>Radiology:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i> 7. <i>Pharmacy:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i> 8. <i>Hemodialysis Centers:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: 2.6.2.6.2 PIHP Contract: None	9. <i>OB/GYN:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 10. <i>Allergy/Immunology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 11. <i>Cardiology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist	
Reference	Required Components
	<p>12. <i>Dermatology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>13. <i>Endocrinology and Metabolism:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>14. <i>Gastroenterology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>15. <i>Hematology/Oncology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>16. <i>Nephrology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>17. <i>Neurology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>18. <i>Ophthalmology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>19. <i>Orthopedics:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i> <p>20. <i>Otorhinolaryngology/Otolaryngology:</i></p> <ul style="list-style-type: none"> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<p>21. <i>Urology:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>22. <i>Psychiatrists:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 30 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 15 miles</i></p> <p>23. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>24. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>25. <i>Specialty Dental Services</i></p> <p style="margin-left: 20px;">a. <i>Travel distance shall not exceed 60 miles one-way from the enrollee’s place of residence for at least 75% of enrollees.</i></p>	
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	
Licensed Mental Health Specialists		
<p>42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract</p> <p>MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None</p>	<p>26. <i>Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 30 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 15 miles</i></p>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/></p>
	<p>Evidence as submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	27. <i>PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization</i> <i>a. Rural and Urban Parishes: 200 miles</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	28. <i>ASAM Level 1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 29. <i>ASAM Level 2.1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 30. <i>ASAM Level 2WM:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
Substance Use Residential Treatment Facilities (adult)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F	31. <i>ASAM Levels 3.1</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 32. <i>ASAM Levels 3.3</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
PAHP Contract: None PIHP Contract: None	33. <i>ASAM Levels 3.5</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 34. <i>ASAM Levels 3.2-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 35. <i>ASAM Level 3.7</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 36. <i>ASAM Level 3.7-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	37. <i>ASAM Level 3.1</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 38. <i>ASAM Level 3.2 Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 39. <i>ASAM Level 3.5</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>	



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Reference	Required Components	
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	40. <i>Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 90 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Behavioral Health Rehabilitation Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	41. <i>Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	Evidence as submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	
Behavioral Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: NA	42. <i>For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA_CSoc - Quarterly_BH_Specialists_Geo WY 2 Q3 LA_CSoc - BH_Specialists_Geo WY3 Q2 2025 LA_CSoc - BH_Specialists_Geo WY3 Q1 2025 LA_CSoc - BH_Specialists_Geo WY2 Q4 	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	43. <i>For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):</i> <ol style="list-style-type: none"> Rural Parishes: 90 miles Urban Parishes: 60 miles 	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	Evidence as submitted by the MCE: <ul style="list-style-type: none"> LA_CSoc - Quarterly_OP_Services_Geo WY2 Q3 LA_CSoc - OP_Services_Geo WY3 Q2 2025 LA_CSoc - OP_Services_Geo WY3 Q1 2025 LA_CSoc - OP_Services_Geo WY2 Q4 	



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Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Care Coordination and Services		
<i>Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).</i>		
<p>1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member.</p> <p style="padding-left: 20px;">a. The member is provided information on how to contact their designated person or entity.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.208(b)(1) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Member materials, such as the member handbook or member notice Primary care provider (PCP) assignment algorithm. Magellan does not have the algorithm for primary care. Screenshot of member identification (ID) card. Magellan does not have ID Cards. Screenshot of fields designating the assigned PCP and assigned case manager. Magellan does not have PCPs for assigned case managers. HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 3 “Dear CSoC Member” p. 40-41 “Coordinated System of Care – Wraparound Agencies” Primary Care Physician and Release of Information Procedure 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • 2024 Louisiana CSoC UMCM Program Description • Primary care provider (PCP) assignment. algorithm. Magellan does not have the algorithm for primary care. • Screenshot of member identification (ID) card. Magellan does not have ID Cards. • Screenshot of fields designating the assigned PCP and assigned case manager. Magellan does not have PCPs for assigned case managers. 	
<p>MCE Description of Process: Magellan does not assign PCP’s, we work with the wraparound agencies and the Healthy Louisiana Plans to ensure all youth have a PCP.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>2. The MCE coordinates the services the MCE furnishes to the member:</p> <ol style="list-style-type: none"> Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. With the services the member receives from any other MCO, PIHP, or PAHP. With the services the member receives in fee-for-service (FFS) Medicaid. With the services the member receives from community and social support providers. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Care management program description • Transition of care program • Workflow for coordinating with other MCOs/ PIHPs/PAHPs • Workflow for coordinating with FFS-Magellan does not have workflow for coordinating with FFS. • Workflow for coordinating with community and social support resources Magellan does not 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>MCO:</p> <ul style="list-style-type: none"> a. <i>Coordinate care between network PCPs and specialists, including specialized behavioral health providers;</i> b. <i>Coordinate care for out-of-network services, including specialty care services;</i> c. <i>Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;</i> d. <i>Coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed.</i> <p>PAHP:</p> <ul style="list-style-type: none"> a. Coordination with the enrollee’s MCO: <ul style="list-style-type: none"> i. <i>for oral health issues exceeding the coverage of the Contract;</i> ii. <i>for transportation to and from covered dental services; and</i> iii. <i>regarding value-added dental benefits offered by the enrollee’s MCO.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.</i> b. <i>Coordinate care for out-of-network services.</i> 	<p>have workflow for coordinating with community and social support resources</p> <ul style="list-style-type: none"> • HSAG will also use the results of the case file reviews <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Workflow for coordinating with FFS. Magellan does not have workflow for coordinating with FFS. • Workflow for coordinating with community and social support resources. Magellan does not have workflow for coordinating with community and social support resources. • Primary Care Physician and Release of Information Procedure pgs 2, 3, 4, 5 • Care Coordination with Agency Involvement pg.2 • Care Coordination General Procedure pg. 2 • Ad Hoc Agreement Procedure pg 1-2 • PRTF-TGH Setting on Referral Date Procedure pg 2 • Special Considerations for Youth in PRTF at Time of Referral pg 2 • Case Management Rounds pg 1,2 • Dual OCDD-CSoC Eligibility Procedure pg 1-2 • 2024 Louisiana CSoC UMCM Program Description 	



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>c. <i>Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.</i></p> <p>d. <i>Coordinate timely with Integrated Medicaid Managed Care Programs and the member’s family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7</p>		
<p>MCE Description of Process: Magellan collaborates with OCDD for youth who have been approved by their agency and/or youth being referred to their agency. We have an ad hoc process to coordinate out of network services. We also collaborate with other state agencies, providers, and Health Plans to ensure youth’s needs are met. Collaboration occurs with HLP’s and guardians after discharge from an inpatient facility.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results of the case management performance evaluation file review identified an opportunity for improvement related to wraparound agency documentation of coordination of services as well as Magellan’s oversight of service provision based on review of authorizations in comparison to claims/services received.</p> <p>Recommendations: HSAG recommends that the MCE continue to evaluate enhancements to oversight processes to ensure timely identification of service provision.</p>		
<p>Required Actions: No action required.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.</i></p> <p style="text-align: right;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8</p>	<p>HSAG Required Evidence:</p> <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Medicaid Care Coordination Policy pgs 3-5 Discharge Coordination of Care Procedure pg 2 <p>Additional Documentation:</p> <ul style="list-style-type: none"> SVI.5_Pol_CSoC Treatment Record Reviews_2024 Case Management Rounds Procedure pg 2 Care Coordination with Agency Involvement Procedure pg 2 2024 Louisiana CSoC UMCM Program Description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan collaborates with the youth’s Healthy Louisiana Plan to address any co-occurring medical needs. When a youth discharges from CSoC, Magellan shares the most recent assessment with the HLP.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Information Sharing		
<p>4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities</p> <p>MCO: a. <i>Upon written request</i></p> <p style="text-align: right;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Workflow for sharing assessment results with the State • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description • Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Discharge Coordination of Care Procedure pg 2 • Case Management Rounds Procedure pg 2 • Care Coordination with Agency Involvement Procedure pg 2 • 2024 Louisiana CSoC UMCM Program Description • Coordination Example 1 • Coordination Example 2 • Coordination Example 3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • SVI.5_Pol_CSoC Treatment Record Reviews_2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCE Description of Process: Magellan shares assessments with HLP’s and state agencies to ensure coordination and collaboration and to prevent duplication.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.</p> <p style="text-align: right;">42 CFR §438.208(b)(5)? per SOW 42 CFR §457.1230(c)? per SOW</p> <p>MCO Contract: 2.8.1.4.7 PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1 PIHP Contract: 16.15</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Provider materials, such as the provider manual and provider contract, Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SIV R5 Care Coordination MHS Organization Site Review section VI SIV R5 Care Coordination LA CSOC Provider Handbook pg 28 SVI R5 Prov Medicaid Addendum Care Coordination pgs 3 and 8 SVI R5 Magellan Provider Agreement Care Coordination pg 11 SVII R5 New Provider Orientation Care Coordination 2024 Louisiana CSoC UMCM Program Description, page 11 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> SVI.5_Pol_CSoC Treatment Record Reviews_2024 – pp. 2–3 SVI.5_Rpt_UM 03 Treatment Record Review Report_Q4 2024 – Monitoring Summary and Review Tool tabs; see orange-highlighted cells and comments. 	
<p>MCE Description of Process: Magellan ensures that each provider maintains and appropriately shares member health records in accordance with federal, state, and contractual requirements. Expectations regarding documentation standards and inter-provider communication are outlined in provider-facing materials. Oversight is operationalized through the Treatment Record Review process, supported by formal policy and monitored quarterly.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>6. The MCE ensures that in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160</p> <p>45 CFR Part 164, Subparts A and E MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PR-BA.1701.06 - PR-BA General Rules for Uses and Disclosures of Protected Health Information (PHI) 2024 Louisiana CSoC UMCM Program Description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The process on how Magellan upholds, maintains and shares member information for specification of services.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Initial Health Risk Screening		
<p>7. The MCE makes a best effort to conduct an initial screening of each member’s needs within MCO:</p> <p style="margin-left: 20px;">a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. <i>The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.</i></p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee’s enrollment to conduct an initial screening of the enrollee’s needs and to offer to schedule the enrollee’s initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Initial screening template Initial screening tracking and monitoring mechanisms and subsequent results/reports HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. <p>Additional Documentation:</p> <ul style="list-style-type: none"> 2024 Louisiana CSOC UMCM Program Description CSOC Member Handbook 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: This does not apply to Magellan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Comprehensive Assessment		
<p>8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.</p> <p>a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(c)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS Comprehensive assessment template HSAG will also use the results of the case file reviews <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Inpatient Rounds Procedure pg 1,2 Information Exchange Procedure pg 2 Physician Advisor Review Procedure pg 2 Care Coordination with Agency Involvement Procedure pg 2 2024 Louisiana CSoC UMCM Program Description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan is able to identify complex health issues through the IBHA, CANS, and ensure they are addressed through the Plan of Care developed by the child and family team.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
Treatment/Service Plan		
<p>9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.</p> <p style="text-align: right;">42 CFR §438.208(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Person centered treatment plan template HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Plan of Care Review Procedure pg 1 2024 Louisiana CSoc UMCM Program Description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: When reviewing the plan of care is when we ensure medical and health needs are met.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>10. The treatment or service plan is:</p> <ol style="list-style-type: none"> a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Case management program description Staff qualifications for developing care plans and service plans (e.g., job description) Service plan approval process Mechanisms to actively involve the member and the member’s formal and informal supports in the development of the treatment plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>c. Approved by the MCE in a timely manner, if this approval is required by the MCE.</p> <p>d. In accordance with any applicable State quality assurance and utilization review standards.</p> <p style="text-align: right;">42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<ul style="list-style-type: none"> Mechanisms to actively involve the member’s PCP (and any other providers involved in the member’s care) in the development of the treatment plan HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Plan of Care Review Procedure pg 1 Medicaid Care Coordination Policy pg 4-5 2024 Louisiana CSoC UMCM Program Description Care Manager Job Description 	
<p>MCE Description of Process: Plans of care for CSoC youth are developed by the child and family team with a wraparound facilitator present from the wraparound agency. Magellan Care Managers review the plans to ensure they meet the needs of the youth and family.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member’s circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3).</p> <p style="text-align: right;">42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Care plan and service plan review and revision tracking mechanism HSAG will also use the results of the case file reviews <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Medicaid Care Coordination Policy pg 5 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Plan of Care Review Procedure pg 1-2 2024 Louisiana CSoC UMCM Program Description 	
<p>MCE Description of Process: The wraparound agency submits the initial plan of care and every reassessment POC (completed every 6 months) to Magellan for review and approval.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Direct Access to Specialists		
<p>12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.</p> <p style="text-align: right;">42 CFR §438.208(c)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Care management program description Member materials, such as the member handbook or benefits grid Provider materials, such as the provider manual or provider contracts <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook pg. 29, sections 1-5 “More Information about the Behavioral Health Care Services Offered” pg. 29-35 “What kind of behavioral health services can you get” SVI R12 Carr Coordination CSoC Provider Handbook Medicaid Care Coordination Policy pg 5 Inpatient Rounds Procedure pg 1,2 Information Exchange Procedure pg 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> Physician Advisor Review Procedure pg 2 Care Coordination with Agency Involvement Procedure pg 2 2024 Louisiana CSoC UMCM Program Description 	
MCE Description of Process: For youth with any medical needs, we collaborate with the youth’s Healthy Louisiana Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VI—Coordination and Continuity of Care						
Total	Met	=	12	X	1	= 12
	Not Met	=	0	X	0	= 0
	Not Applicable	=	0			
Total Applicable		=	12	Total Score	=	12

Total Score ÷ Total Applicable	=	100%
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Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
Coverage		
<p>1. The MCE:</p> <p style="margin-left: 20px;">a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer.</p> <p style="margin-left: 20px;">b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B.</p> <p style="margin-left: 20px;">c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.</p> <p style="margin-left: 40px;">42 CFR §438.210(a)(1-2)</p> <p style="margin-left: 40px;">42 CFR §438.210(a)(3)(i)</p> <p style="margin-left: 40px;">42 CFR §440.230</p> <p style="margin-left: 40px;">42 CFR §441 Subpart B</p> <p style="margin-left: 40px;">42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3</p> <p>PAHP Contract: 2.4.1.4</p> <p>PIHP Contract: 4.1.2; 4.1.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures, Member materials, such as the member handbook and benefits grid Utilization Management (UM) program description Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSOC Member Handbook, pg. 25, Member Bill of Rights, “Get health care services that the law says you should have”. pg. 29, More Information about the Behavioral Health Care Services Offered, “What kinds of behavioral health services can you get?” Medicaid Service Authorization Determination Policy pg 3 POC Review Procedure pg 1 2024 Louisiana CSoc UCMCM Program Description <p>Additional Documentation:</p> <ul style="list-style-type: none"> CSoc Initial Plan of Care Review Workflow CSoc Subsequent Plan of Care Review Workflow 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCE Description of Process: Authorizations are built from the plan of care developed by the child and family team.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right;">42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Coverage guidelines/criteria <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • POC Review Procedure pg 1 • Medicaid Service Authorization Determination Policy pg 3 • 2024 Louisiana CSoc UMCM Program Description • UM Program Policy pg 2 • LA CSoc MNC 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Authorizations are built from the plan of care and based on medical necessity criteria (MNC) and are not determined by diagnosis, type of illness, or condition of the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Utilization management plan • Member materials, such as the member handbook 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCO, PAHP, and PIHP:</p> <p>a. The services furnished can reasonably achieve their purpose.</p> <p>MCO and PIHP:</p> <p>a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that reflects the member’s ongoing need for such services and supports.</p> <p>b. Family planning services are provided in a manner that protects and enables the member’s freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.</p> <p style="text-align: right;">42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10</p>	<ul style="list-style-type: none"> Coverage guidelines/criteria, <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSOC Member Handbook, pg. 29, More Information about the “Behavioral Health Care Services Offered”, “What kinds of behavioral health services can you get?”, pgs. 34-35, “Medical Service”, sections 1-3. Medicaid Service Authorization Determination Policy pg 3 UM Program Policy pg 2 LA CSoC MNC <p>Additional Documentation:</p> <ul style="list-style-type: none"> Screenshot of Training Courses Creating a Course in Rise 360 	
MCE Description of Process: Authorizations are built based on the plan of care and medical necessity criteria.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>4. The MCE specifies what constitutes “medically necessary services” in a manner that:</p> <p>a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Member materials, such as the member handbook 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and</p> <p>b. Addresses the extent to which the MCE is responsible for covering services that address:</p> <p style="margin-left: 20px;">i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability.</p> <p style="margin-left: 20px;">ii. The ability for a member to achieve age-appropriate growth and development.</p> <p style="margin-left: 20px;">iii. The ability for a member to attain, maintain, or regain functional capacity.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(a)(5)</p> <p>MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11</p>	<ul style="list-style-type: none"> Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SVII R4 Coverage and Auth CSoc Provider Handbook pgs 15,46,51 VII R4 Cove. and Auth National Provider Handbook NTW Part, Approp. LOC, FWA Overpymt Sections CSOC Member Handbook, pg. 29, More Information about the Behavioral Health Care Services Offered, “What kinds of behavioral health services can you get?” Medicaid Service Authorization Determination Policy pg 4 2024 Louisiana CSoc UCMCM Program Description 	
<p>MCE Description of Process: Routine authorizations are built based on the plan of care and medical necessity criteria.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Authorization of Services		
<p>5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(b)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Coverage guidelines/criteria 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1</p>	<ul style="list-style-type: none"> List of delegated entities performing utilization management Delegated written contract (for entities responsible for delegated UM functions) Delegation oversight of policies and procedures (e.g., audit results) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> List of delegated entities performing utilization management. Magellan does not delegate. Delegated written contract (for entities responsible for delegated UM functions). Magellan does not delegate. Delegation oversight of policies and procedures (e.g., audit results). Magellan does not delegate. 2024 Louisiana CSoC UMCM Program Description UM Program Policy pg 2 NonAuth Lack of Participation in UM Process pg 1 LA CSoC MNC <p>Additional Documentation:</p> <ul style="list-style-type: none"> CM Daily Call Procedure CSoC IP Census Example Review Dates in EHR 	
<p>MCE Description of Process: Magellan care managers handle all initial and concurrent authorization requests and there is no delegation.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of inter-rater reliability (IRR) activities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Medicaid Service Authorization Determination Policy pg 4 • Benefit Certification Appeal General Guidelines Policy pg 11-12 • 2024 Louisiana CSoC UMCM Program Description • LA CSoC MNC • 2024 MNC IRR Results <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Medical Necessity Policy-pg. 3. This is from 2023 and was in effect until 3.2025. • CM Quality Call Review 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: Magellan has Medical Necessity Criteria our care managers and physician reviewers use to determine authorizations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>7. The MCE consults with the requesting provider for medical services when appropriate.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications GF • Three case examples of peer-to-peer consults <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • S VII R7 Coverage and Auth of Services New Provider Orientation Slide 22 • S VII R7 Coverage and Auth CSoC Provider Handbook pg 25 • Benefit Certification Appeal General Guidelines Policy pg 16 • Medicaid Service Authorization Determination Policy pg. 4 • Peer to Peer Example 1 • Peer to Peer Example 2 • Peer to Peer Example 3 • 2024 Louisiana CSoC UMCM Program Description 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: During the telephonic review, a care manager can send the review to a physician advisor review to determine medical necessity criteria or for complexity.</p>		
<p>HSAG Findings: HSAG has scored this element as not applicable since State requirements differ from federal requirements. LDH’s contract includes an informal reconsideration process; however, CMS has articulated that the MCEs’ practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member a notice of adverse benefit determination (ABD) is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS’ definition of an appeal. HSAG has communicated</p>		



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Requirement	Supporting Documentation	Score
this information to LDH. It should be noted, the MCE’s peer-to-peer process in determining authorization appeared to meet State requirements while not overturning denial decisions in a manner that contradicts the CMS appeal guidelines.		
Required Actions: No action required.		
8. The MCE authorizes LTSS based on a member’s current needs assessment and consistent with the person-centered service plan. <div style="text-align: right; margin-right: 100px;">42 CFR §438.210(b)(2)(iii)</div> MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Authorization workflow for LTSS UM program description Coverage guidelines/criteria Three examples of authorized LTSS and copies of the corresponding person-centered service plans Evidence as Submitted by the MCE: <ul style="list-style-type: none"> This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process: NA		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member’s medical, behavioral health. MCO: a. <i>The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and</i>	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures UM program description Job descriptions for UM decision makers HSAG will also use the results of the Service Authorization Denial File Review Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Physician Advisor Review Procedure pg 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p><i>training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.</i></p> <p>PAHP:</p> <p>a. <i>Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee’s condition.</i></p> <p style="text-align: right;">42 CFR §438.210(b)(3) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3</p>	<ul style="list-style-type: none"> Initial Inpatient Psychiatric Review Procedure pg 4 Concurrent Inpatient Psychiatric Review Procedure pg 3 Concurrent Inpatient Detox Review Procedure pg 3 Medicaid Service Authorization Determination Policy pg. 4 2024 Louisiana CSoC UCMCM Program Description Care Manager Job Description Physician Advisor Job Description Medical Director Job Description 	
<p>MCE Description of Process: In order for a service to be clinically denied as not meeting medical necessity criteria, the case must be reviewed by one of our physician reviewers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Notice of Adverse Benefit Determination		
<p>10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.</p> <p>MCO:</p> <p>a. <i>The MCO shall provide written notification to the provider rendering the service, whether a health care</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Provider notice template HSAG will also use the results of the Service Authorization Denial File Review 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>professional or facility or both, within two (2) Business Days of making the determination.</i></p> <p>PIHP:</p> <p>a. <i>The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The PIHP shall notify the provider rendering the service, verbally as expeditiously as the member’s health condition requires, but not more than one (1) business day of making the initial determination and shall provide written confirmation of such notification to the provider within two (2) business days of making the initial determination.</i></p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Timing of Service Authorization Decisions Procedure pg. 3 2024 Louisiana CSoC UMCM Program Description CSoC Inpt Clinical Full Denial CSoC Inpt Clinical Partial Denial 	
<p>MCE Description of Process: When a non-authorization is determined, the provider is notified verbally as well as the member and provider are notified via written LDH approved letter.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. The MCE defines an adverse benefit determination (ABD) as:</p> <p>a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity,</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>appropriateness, setting, or effectiveness of a covered benefit.</p> <p>b. The reduction, suspension, or termination of a previously authorized service.</p> <p>c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an ABD.</p> <p>d. The failure to provide services in a timely manner, as defined by the State.</p> <p>e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.</p> <p>f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.</p> <p>g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.</p> <p style="text-align: right;">42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2)</p> <p>MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1</p>	<ul style="list-style-type: none"> SVII R11 Coverage and Auth Adverse Claim Determinations Policy SVII Coverage an Authorization of Services CSoC Provider Handbook p25 S VII R11 Coverage and Auth of Services New Provider Orientation Slide 38 CSOC Member Handbook, pgs. 20-21, “Appeal and State Fair Hearing Procedures for Eligibility”, sections 1-15, pgs.16-17 “How do I change providers”, sections 1-3, “How do I get a second opinion”, section 1, pgs, 18-19, “Grievances”, sections 1-5. Medicaid Service Authorization Determination Policy pg 5 	



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The process for coverage and authorization of adverse claim determinations, coverage and authorization of services for providers appeals, state fair hearings and eligibility procedures, grievances and the procedure to a second opinion and the Medicaid Service Authorization Determination process.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following:</p> <ol style="list-style-type: none"> a. The ABD the MCE has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. c. The member’s right to request an appeal of the MCE’s ABD, including information on exhausting the MCE’s one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Medicaid Service Authorization Determination Policy pgs 8-10 • CSoC Inpt Clinical Full Denial • CSoC Inpt Clinical Partial Denial • 2024 Louisiana CSoC UMCM Program Description <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Medical QI QA Review Tool UM Denial 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>f. The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.</p> <p>g. The notice must be consistent with the requirements of 42 CFR §438.10.</p> <p style="text-align: center;">42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2</p>		
<p>MCE Description of Process: When a service is non-authorized, a letter approved by LDH is mailed to member/guardian.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The case file review indicated that Magellan was not evaluating notices of ABD for reading grade level. In virtual review, staff described the use of Flesch-Kincaid to monitor reading level, including its process for checking the reading grade level of the applicable language. Magellan staff members stated its compliance department conducts a review on 100 percent of the notices of ABD and post-virtual submitted a QI QA Review Tool UM Denial as evidence. However, this tool did not demonstrate review of reading grade level.</p>		
<p>Required Actions: The MCE must ensure that member notifications meet state-required reading levels and that the MCE’s documentation of reading levels for case files is accurately demonstrated. The MCE should add functionality to the system that houses and tracks prior authorization requests and resolutions so that users may document that notices of ABD include all requirements and indicate that the reading grade level has been verified.</p>		



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Requirement	Supporting Documentation	Score
Timeframe for Decisions		
<p>13. For standard authorization decisions, the MCE provides notice as expeditiously as the member’s condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Medicaid: Service Authorization Determination Policy pg. 6 • Timing of Service Authorization Decisions Procedure pg. 2 • CM02-WY2 Q3 Auth Timeliness • CM02-WY2 Q4 Auth Timeliness • CM02-WY3 Q1 Auth Timeliness • CM02-WY3 Q2 Auth Timeliness • 2024 Louisiana CSoc UCMCM Program Description 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan reviews authorization requests in the established timeframes based on the type of request.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Timeliness tracking sheets submitted by Magellan and the case file review demonstrated noncompliance with timeliness for processing standard authorizations. In addition, the case file review indicated noncompliance with timeliness on some case samples.</p>		



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Requirement	Supporting Documentation	Score
Required Actions: The MCE must develop a process for ensuring timely processing of standard authorizations.		
<p>14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later 72 hours after receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Timing of Service Authorization Decisions Procedure pg. 2 • Medicaid Service Authorization Determination Policy pg. 7 • CM02-WY2 Q3 Auth Timeliness • CM02-WY2 Q4 Auth Timeliness • CM02-WY3 Q1 Auth Timeliness • CM02-WY3 Q2 Auth Timeliness • 2024 Louisiana CSoC UMCM Program Description 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Magellan makes a decision on expedited requests within the 72-hour timeframe.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		



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Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member, or the provider, requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member’s interest.</p> <p style="margin-left: 100px;">42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(e)(3)</p> <p>MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description Tracking and reporting mechanisms Extension notice template Three case examples of authorizations with an extension, including the date of receipt of the authorization request and date of the decision to extend the time frame HSAG will also use the data from the universe file HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Timing of Service Authorization Decisions Procedure pg. 2 There are no extensions to report 2024 Louisiana CSoc UCMCM Program Description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: There have not been any extension requests to report.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it:</p> <p>a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and</p> <p>b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.</p> <p style="padding-left: 40px;">42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension. • HSAG will also use the results of the Service Authorization Denial File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Three case examples of authorizations with an extension, including the written notice of the extension. Magellan does not have any case examples. • Medicaid Service Authorization Determination Policy pgs 7-8 • 2024 Louisiana CSoC UMCM Program Description 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: There have not been any extension requests to report.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA).</p> <p>a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.</p> <p style="text-align: right;">42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)</p> <p>MCO Contract: None PAHP Contract: NA PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Three examples of notice <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • This does not apply to Magellan. 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
MCE Description of Process: NA		
HSAG Findings: The MCE reported it did not authorize outpatient drug decisions; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214.</p> <p style="text-align: right;">42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Three case examples of advance notices, including the ABD notice and the effective date of decision. HSAG will also use the data from the universe file 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1</p>	<ul style="list-style-type: none"> HSAG will also use the results of the service authorization denial file review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Medicaid Service Authorization Determination Policy pg. 11 Intent to Discharge Letter Detention Final Intent to Discharge Letter Non-HCBS Setting Final Intent to Discharge Letter Example 1 Intent to Discharge Letter Example 2 Intent to Discharge Letter Example 3 2024 Louisiana CSoC UCMCM Program Description Intent to Discharge Workflow 	
<p>MCE Description of Process: When a youth is going to be disenrolled from the program, a LDH approved letter is mailed out to the guardian to notify them of disenrollment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>19. The MCE may send a notice not later than the date of action if:</p> <p style="margin-left: 20px;">a. The MCE has factual information confirming the death of a member;</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description ABD notice template(s) Tracking and reporting mechanism(s) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The MCE receives a clear written statement signed by a member that:</p> <ul style="list-style-type: none"> i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information; <p>c. The member has been admitted to an institution where the member is ineligible under the plan for further services;</p> <p>d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address;</p> <p>e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;</p> <p>f. A change in the level of medical care is prescribed by the member’s physician;</p> <p>g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or</p> <p>h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i).</p> <p style="text-align: right;">42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii)</p>	<ul style="list-style-type: none"> • Three examples of an ABD notice sent to a member that meets one of the criteria of this element; one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Medicaid Service Authorization Determination Policy pg. 11 • 2024 Louisiana CSoC UCMCM Program Description • Notification of Discharge Letter Disenrollment Letter • CSoC Intent to Discharge Workflow • Intent to Discharge Process • Ineligible Letter Example 	



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3</p>		
<p>MCE Description of Process: We have been given guidance from LDH not to mail out letters when there is a death of a member. When a member’s guardian chooses to disenroll, we send out the Notification of Discharge letter. We follow the Intent to Discharge Process for all discharges that follow one of those scenarios. When a youth is clinically ineligible on the CANS, we send out the Ineligible Letter to notify the guardian.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>20. The MCE may shorten the period of advance notice to five days before the date of action if:</p> <p style="padding-left: 20px;">a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and</p> <p style="padding-left: 20px;">b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right;">42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • Three examples of an ABD notice sent to a member due to probable fraud. HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Three examples of an ABD notice sent to a member due to probable fraud. Magellan does not have an example of this. • Medicaid Service Authorization Determination Policy pg 11 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> 2024 Louisiana CSOC UCMCM Program Description 	
MCE Description of Process: We have not had any instances of this, so there are no examples.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim.</p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Workflow/guidelines for payment denial on a claim to trigger ABD notice UM program description ABD notice template for denial of payment Tracking and reporting mechanism(s) Three case examples of the denial of payment on a claim, including date of the denial and ABD notice, HSAG will also use the data from the universe file HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SVII R21 Adverse Claim Determinations - Policy pg 4 SVIII R21 Coverage and Authorization Claim SLC8001289558 EX 1 SVIII R21 Coverage and Authorization SLC8001289558 EX 1_Claim_228253378_EOB 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> SVIII R21 Coverage and Authorization SLC8001289558 EX 1-2 SVIII R21 Coverage and Authorization Claim SLC8000316040 EX 2 SVIII R21 Coverage and Authorization SLC8000316040 EX 2_Claim 228066809_EOB SVIII R21 Coverage and Authorization SLC8000316040 EX 2-2 SVIII R21 Coverage and Authorization Claim SLC8000021029 EX 3 SVIII R21 Coverage and Authorization SLC8000021029 EX 3_Claim_226678592_EOB SVIII R21 Coverage and Authorization SLC8000021029 EX 3-2 2024 Louisiana CSoC UMCM Program Description 	
<p>MCE Description of Process: The process for adverse claim determinations, coverage and authorization for claims and Utilization Management Activities.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire.</p> <p style="text-align: right;">42 CFR §438.210(c-d)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description ABD notice template for untimely determination Service authorization log(s) within the time period under review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7</p>	<p>42 CFR §438.404(c)(5) 42 CFR §457.1230(d)</p> <ul style="list-style-type: none"> Tracking and reporting mechanism(s) Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice HSAG will also use the data from the universe file HSAG will also use the results of the Service Authorization Denial File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Medicaid Service Authorization Determination Policy pg 6 2024 Louisiana CSoc UCMCM Program Description Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice- there are no examples of this situation 	
<p>MCE Description of Process: There are no instances in which there was a denial not issued within the appropriate timeframe.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Compensation for Utilization Management Activities		
<p>23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures UM program description New hire and ongoing training for staff 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>or entity to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27</p>	<ul style="list-style-type: none"> Three examples of staff attestations <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 2024 Louisiana CSoc UCM Program Description Medicaid Service Authorization Determination Policy pg 4 2024 Conflict of Interest Training 	
<p>MCE Description of Process: Utilization Management Activities, Medicaid Service Authorization Determination guide, and Magellan staff complete a conflict of interest training.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard VII—Coverage and Authorization of Services							
Total	Met	=	18	X	1	=	18
	Not Met	=	2	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	20	Total Score		=	18

Total Score ÷ Total Applicable	=	90%
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Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
General Rules		
<p>1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214.</p> <p>MCO: For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff.</p> <p style="text-align: right;">42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Credentialing Program Description, pages 2-4, and 11 • CSoc Network Development and Management Plan. pages 76-77 • Network Organizational Provider Assessment - CR.1117.04 - Policy, All pages <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Provider Credentialing and Recredentialing Process CR.1107.06 Revised 8.26.25 Provider Retention 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan has implemented written policies and procedures governing the selection and retention of network providers that fully align with the requirements set forth in 42 CFR §438.214. These policies address credentialing and recredentialing processes, nondiscrimination, network sufficiency, and the verification of provider qualifications. Our procedures ensure all contracted providers meet applicable state and federal standards, and documentation of these practices is maintained for audit and regulatory review.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan did not have written policies and procedures for retention of network providers during the review time frame.</p>		
<p>Required Actions: The MCE must implement written policies and procedures for retention of network providers that at a minimum meet the requirements of 42 CFR §438.214.</p>		



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Requirement	Supporting Documentation	Score
<p>2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types:</p> <p style="margin-left: 20px;">a. Acute; b. Primary; c. Mental health; d. Substance use disorders.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, All pages • CSoC Network Development and Management Plan. pages 76-77 • Network Organizational Provider Assessment - CR.1117.04 - Policy, All pages 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Magellan follows a documented credentialing and recredentialing process that meets all State requirements for each applicable provider type, including mental health, and substance use disorder providers. Our process includes verification of licensure, education, training, experience, board certification (if applicable), and any required sanctions or exclusions. These standards are consistently applied during both initial credentialing and recredentialing to ensure that all network providers meet established qualifications and continue to deliver safe, quality care. Support documentation has been provided.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Nondiscrimination		
<p>3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(c)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p style="text-align: right;">42 CFR §438.12 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Credentialing Program Description, pages 7-8 CSoC Provider Handbook, page 1 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Credentialing Program Description - CR.1114.11 - Policy VIII R3 	
<p>MCE Description of Process: Our network provider selection policies and procedures are designed to comply with 42 CFR §438.12 and expressly prohibit discrimination against providers that serve high-risk populations or specialize in treating costly conditions. All providers are evaluated based on established, objective criteria related to quality, access, and service needs. We remain committed to ensuring equitable network access for all members, including those with complex or high-cost care needs, and our selection process reflects this commitment.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.</p> <p style="margin-left: 20px;">a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.</p> <p style="margin-left: 20px;">b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214.</p> <p style="text-align: right;">42 CFR §438.12 (a)(1-2)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider notice template(s) for adverse credentialing and/or contracting decisions Examples of one individual and one organizational executed provider contracts Nondiscrimination statement for credentialing committee members Mechanism for monitoring for discriminatory practices HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p style="text-align: right;">42 CFR §438.214 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Credentialing Program Description - Section C, pages 7-8 CSoC Provider Handbook, page 10 Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Page 22, B Minnie Joyce Crawford Individual Agreement Maries Family Healthcare & Sitter Service Organizational Agreement <p>Additional Documentation:</p> <ul style="list-style-type: none"> TEMPLATE Individual Pvdr Term for Cause admin rvw_v2018 v2 TEMPLATE Initial Denial Letter with Admin Rvw_v2018 v2 Credentialing Program Description - CR.1114.11 - Policy VIII R3 	
<p>MCE Description of Process: We do not discriminate in the participation, reimbursement, or indemnification of any provider acting within the scope of their license or certification under applicable State law, in accordance with 42 CFR §438.214. Our provider selection and contracting processes are non-discriminatory and based on objective criteria related to network adequacy, quality, and service needs. If we decline to include an individual or group of providers in our network, we provide written notice stating the reason for the decision.</p> <p>We maintain notification templates to ensure consistency and compliance when communicating decisions related to provider network participation. These templates are used to inform individual or group providers in writing of the reason for denial if they are not accepted into the network, in accordance with 42 CFR §438.214. While the templates are not available at this time, we can confirm that they align with regulatory requirements and are used as part of our standard provider selection and contracting process.</p>		



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<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policy and procedure did not include language that stated it does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.</p>		
<p>Required Actions: The MCE must revise the policy and procedure to include language that states Magellan does not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.</p>		
Excluded Providers		
<p>5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.</p> <p style="text-align: right;">42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3</p> <p>MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity. • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Page 12, Number 12, and Letter F 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> VII Provider Selection R5 Exclusion Checks Examples Provider Network Ongoing Monitoring -SVIII Provider Selection Exclusion Section II Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity. Magellan does not delegate this activity. 	
<p>MCE Description of Process: We do not employ or contract with any providers who are excluded from participation in Federal health care programs under Section 1128 or Section 1128A of the Social Security Act. As part of our credentialing, recredentialing, and ongoing monitoring processes, we conduct routine checks against the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM) to ensure compliance with this federal requirement.</p> <p>Our contracted providers are also responsible for conducting monthly exclusion checks for their staff against the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM). We monitor provider compliance with this requirement through routine audits and reviews to ensure adherence to federal and contractual obligations.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
State Requirements		
<p>6. The MCE complies with any additional requirements established by the State.</p> <p>MCO:</p> <p>i. <i>The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or that it has verified and confirmed that the provider is enrolled with the State.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Three consecutive months of attestations submitted to LDH HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>ii. <i>The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.</i></p> <p>iii. <i>The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]</i></p> <p>PIHP:</p> <p>a. <i>An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.</i></p> <p>b. <i>The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor or any person defined above or under the provisions of Section</i></p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Provider Network Ongoing Monitoring - NE.1318.07 - Policy, pages 1-4 • CSoc Provider Handbook, Fraud, Waste and Abuse, pages 54-58 • Semi Annual Report Cred_Contracting Data May 2024 • Semi Annual Report Cred_Contracting Data May 2025 • Semi Annual Report Cred_Contracting Data November 2024 • PI exclusion Database Attestation Dec 2024 • PI Exclusion Database Attestation Jan. 2024 • PI Exclusion Database Attestation May 2024 	



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<p><i>1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.</i></p> <p style="text-align: right;">42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4</p>		
<p>MCE Description of Process: We are compliant with the requirement to notify LDH within three (3) business days upon receiving notice that action is being taken against the Contractor or any affiliated individual, as defined in 48 CFR §2.101, that could result in exclusion, debarment, or suspension under Section 1128(a) or (b) of the Social Security Act (42 U.S.C. §1320a-7) or any program listed in Executive Order 12549. Internal protocols are in place to promptly escalate such notices to designated compliance personnel to ensure timely reporting to LDH, as required.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Verification of Credentials		
<p>7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision.</p> <p style="padding-left: 20px;">a. <i>The MCE verifies the license directly from the state licensing or certification agency (or its website).</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Verification Section, page 8-13, and page 12 E 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>MCE Description of Process: As part of our credentialing and recredentialing process, we conduct primary source verification to ensure each practitioner holds a current and valid license to practice in all states where they provide care to our members. This verification is completed within 180 calendar days of the credentialing decision and is obtained directly from the applicable state licensing or certification agency, including through the agency’s official website. This step is a standard part of our credentialing protocol to ensure compliance with regulatory requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. One practitioner recredentialing file did not verify compliance with primary source verification requirements, specifically related to required documentation elements.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must complete primary source verification that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision. Additionally, the MCE must verify the license directly from the state licensing or certification agency (or its website).</p>		
Practitioner Verification of Credentials		
<p>8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner’s Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision.</p> <p style="padding-left: 20px;">a. <i>This requirement does not apply to practitioners who are not qualified to write prescriptions.</i></p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, For prescribers section, page 4 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: MCE Description of Process: As part of our credentialing and recredentialing process, we conduct primary source verification to confirm that each practitioner’s Drug Enforcement Administration (DEA) and, where applicable, Controlled Dangerous Substances (CDS) certificate is current and valid in every state where the practitioner provides care to our members. This verification is completed at the time of the credentialing decision. This requirement does not apply to practitioners who are not authorized to prescribe medications, and we ensure proper exclusion in such cases based on the practitioner’s scope of practice.</p>		



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<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision:</p> <p style="margin-left: 20px;">a. <i>Board certification;</i> b. <i>Residency; or</i> c. <i>Graduation from medical or professional school.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Page 3 IV A 	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we verify the board certification status of practitioners, where applicable, within 180 calendar days of the credentialing decision. This verification is conducted through primary source methods, such as directly contacting the certifying board or using a recognized verification service. Board certification verification does not apply to nurse practitioners (NPs) or other healthcare professionals unless we communicate board certification status to members. This process ensures compliance with state and federal credentialing requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Five initial credentialing files did not verify compliance with primary source verification documentation requirements, specifically that the licensing boards conducted primary source verification of education and training.</p>		
<p>Required Actions: For credentialing, the MCE must complete primary source verification for the highest of the following three levels of education and training obtained by a practitioner as appropriate prior to the credentialing decision:</p> <p style="margin-left: 20px;">a. Board certification; b. Residency; or c. Graduation from medical or professional school.</p>		



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Additionally, if Magellan utilizes a state licensing agency, specialty board, or registry, Magellan must obtain evidence that ensures the organization performs primary source verification.		
<p>10. For credentialing and recredentialing, the MCE verifies the practitioner’s board certification status, if applicable, within 180 calendar days of the credentialing decision.</p> <p>a. <i>Verification of board certification does not apply to nurse practitioners (NPS) or other health care professionals unless the MCO communicates board certification to members.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Section X, C 2 and 3, page 13-14, and page 14 Ca 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Magellan complies with the requirement to verify board certification status, when applicable, within 180 calendar days of the credentialing decision. This verification is conducted for applicable practitioner types for whom board certification is relevant. Our credentialing policies and procedures reflect this requirement, and documentation of board certification verification is maintained in the practitioner’s credentialing file when applicable.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>11. For credentialing, the MCE verifies the practitioner’s work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision.</p> <p>a. <i>If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.</i></p> <p>b. <i>If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Page 8- 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p><i>MCE documents a verbal clarification or includes the written notice in the practitioner’s credentialing file.</i></p> <p>c. <i>If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>Section VII numbers 8 & 9; Page 11- Number 6. Element: Work History Section</p>	
<p>MCE Description of Process: As part of our credentialing process, we verify a minimum of the most recent five years of a practitioner’s work history within 365 calendar days of the credentialing decision. If the practitioner has fewer than five years of work history, we begin verification from the date of initial licensure.</p> <p>For any employment gap exceeding six months, the practitioner is required to provide clarification either verbally or in writing. Verbal clarifications are documented by our staff, and written explanations are maintained in the credentialing file. If a gap exceeds one-year, written clarification from the practitioner is required and our review of the explanation is documented in the credentialing file. These practices ensure compliance with credential standards and support a thorough evaluation of practitioner history.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Section VII, number 11 page 8, page 11 number 7; page 13 -14 Section X, C Numbers 2 & 3, and page 12 Ca 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>MCE Description of Process: As part of our credentialing and recredentialing process, we verify the practitioner’s history of professional liability claims that resulted in a settlement or judgment paid on their behalf. This verification is completed within 180 calendar days of the credentialing decision and is obtained either from the practitioner’s malpractice carrier or through a query to the National Practitioner Databank (NPDB). All findings are reviewed and considered as part of the credentialing determination to ensure compliance with state and federal requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Practitioner Sanction Information		
<p>13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> ● Policies and procedures ● HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> ● Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy Page 9, Number 2 Element: Licensure verification, pages 13-14, Section X, C, Numbers 2-3, page 14 Ca 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we verify any state sanctions, restrictions on licensure, and limitations on scope of practice for each practitioner within 180 calendar days of the credentialing decision. This verification is conducted through primary source methods, typically using the applicable state licensing board’s official website or database. Any identified issues are reviewed and documented as part of the credentialing file and considered in the final determination to ensure regulatory compliance.</p>		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Five organizational credentialing files and four organizational recredentialing files did not include primary source verification of state sanctions, restrictions on licensure, and limitations of scope of practice.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, the MCE must verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</p>		
<p>14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, page 13, IX, A2, pages 13-14, Page 14 Ca, Section X, C, Numbers 2-3 and page 15 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we verify Medicare and Medicaid sanctions for each practitioner within 180 calendar days of the credentialing decision. This verification is conducted through primary sources, including the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and the System for Award Management (SAM). Any identified sanctions are reviewed and documented in the practitioner’s credentialing file and factored into the final credentialing determination in compliance with regulatory requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. One practitioner recredentialing file contained documentation of the Office of Inspector General (OIG) verification for a different practitioner other than for the practitioner whose file was under review. One organizational recredentialing file did not include OIG primary source verification documentation.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must verify the Medicare and Medicaid sanctions within 180 days of the credentialing decision. Magellan must also ensure the credentialing file contains documentation of OIG exclusion verification specific to the practitioner under review.</p>		



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Requirement	Supporting Documentation	Score
Practitioner Credentialing Application/Attestation		
<p>15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include:</p> <ol style="list-style-type: none"> a. <i>Reasons for inability to perform the essential functions of the position;</i> b. <i>Lack of present illegal drug use;</i> c. <i>History of loss of license and felony convictions;</i> d. <i>History of loss or limitation of privileges or disciplinary actions;</i> e. <i>Current malpractice insurance coverage; and</i> f. <i>Current and signed attestation confirming the correctness and completeness of the application.</i> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, page 14 XII, A, B, and C pages 14-15 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we ensure that each practitioner completes an application and attestation that includes the following required elements:</p> <ol style="list-style-type: none"> a. Disclosure of any reasons for inability to perform the essential functions of the position; b. Confirmation of no current illegal drug use; c. Disclosure of any history of loss of licensure and any felony convictions; d. Disclosure of any history of loss or limitation of privileges or other disciplinary actions; e. Proof of current malpractice insurance coverage; and f. A current, signed attestation confirming that the information provided in the application is complete and accurate. <p>These elements are required for both initial credentialing and recredentialing, and the signed attestation is maintained in the practitioner’s credentialing file in accordance with regulatory and contractual standards</p>		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The certificate of insurance for one practitioner’s initial credentialing file did not show the practitioner was explicitly covered under the policy. One practitioner recredentialing file included a letter dated 2021 stating the practitioner was afforded medical malpractice through the Louisiana State University Health Sciences Center; however, the documentation was not current at the time of the signed attestation.</p>		
<p>Required Actions: For credentialing and recredentialing, the MCE must ensure that the application and attestation include current malpractice insurance coverage.</p>		
Practitioner Monitoring		
<p>16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by:</p> <p style="margin-left: 20px;">a. <i>Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);</i></p> <p style="margin-left: 20px;">b. <i>Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and</i></p> <p style="margin-left: 20px;">c. <i>Implementing appropriate interventions when it identifies instances of poor quality.</i></p> <p style="text-align: right; margin-right: 20px;">2 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Provider complaints tracking reports Provider adverse events tracking reports Credentialing committee meeting minutes Two examples of interventions taken based on poor quality of care 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, page 19 Section XVIII Credentialing Program Description Page 5, Letter C Provider Network Ongoing Monitoring - NE.1318.07 - Policy, pages 1-4 		
<p>MCE Description of Process: We have established and implemented policies and procedures for the ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles. This includes:</p>		



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Requirement	Supporting Documentation	Score
<p>a. Complaints: We collect and review member and provider complaints on an ongoing basis. A comprehensive evaluation of each practitioner’s complaint history is conducted at least every six months to identify trends or patterns that may indicate performance or quality concerns.</p> <p>b. Adverse Events: We monitor for adverse events—including critical incidents and other reportable occurrences—at least every six months. These are reviewed for potential clinical or operational risks.</p> <p>c. Interventions: When we identify instances of poor quality, appropriate interventions are implemented, which may include education, corrective action plans, enhanced monitoring, or removal from the network, depending on the severity of the issue.</p> <p>All monitoring activities and interventions are documented and aligned with contractual and regulatory requirements to ensure network integrity and member safety.</p>		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Organizational Verification of Credentials		
<p>17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of organizational provider types and corresponding licensing body in the State of Louisiana • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Credentialing Program Description, page 2, Policy Statement 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we confirm that each provider is in good standing with applicable state and federal regulatory bodies. This includes verification through primary sources such as state licensing boards, the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), and the System for Award Management (SAM). Any findings are</p>		



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Requirement	Supporting Documentation	Score
<p>reviewed and documented in the provider’s credentialing file to ensure compliance with regulatory standards and to support informed credentialing decisions.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.</p> <p style="margin-left: 20px;">a. <i>If the provider is not accredited, the MCE conducts an onsite quality assessment.</i></p> <p style="margin-left: 40px;">i. <i>The MCE has a process for ensuring that the provider credentials their practitioners.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Onsite assessment review tool/template HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Network Organizational Provider Assessment - CR.1117.04 - Policy, page 3, Section IV and page 4, 3b Site Review, page 1 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: As part of our credentialing and recredentialing process, we confirm whether each provider has been reviewed and approved by a recognized accrediting body. If a provider is not accredited, we conduct an onsite quality assessment to evaluate compliance with applicable standards and ensure service quality.</p> <p>Additionally, we have a defined process to ensure that each contracted provider has a credentialing program in place and credentials their practitioners in accordance with State and contractual requirements. This includes regular review of provider credentialing policies and, where applicable, validation during audits or site visits.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one organizational recredentialing file did not confirm that the organization was approved by an accrediting body or that Magellan conducted an on-site quality assessment if the provider was not accredited.</p>		



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Requirement	Supporting Documentation	Score
<p>Required Actions: For credentialing and recredentialing, the MCE must confirm that a provider has been reviewed and approved by an accrediting body; if the provider is not accredited, the MCE must conduct an on-site quality assessment. Furthermore, the MCE must have a process for ensuring that the provider credentials its practitioners.</p>		
Time Frames		
<p>19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Recredentialing timeliness report during the review period HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Network Organizational Provider Assessment - CR.1117.04 - Policy, Page 6, V. A Network Practitioner Credentialing and Recredentialing - CR.1102.25 - Policy, Page 18 XVII. A 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: We ensure that our credentialing process includes mandatory recredentialing of all network practitioners at least every 36 months, in accordance with NCQA requirements and applicable state and contractual standards. This process includes verification of licensure, sanctions, professional liability history, and other credentialing elements to confirm continued qualifications and competency.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Results for Standard VIII—Provider Selection					
Total	Met	=	11	X	1 = 11
	Not Met	=	8	X	0 = 0
	Not Applicable	=	0		
Total Applicable		=	19	Total Score	= 11

Total Score ÷ Total Applicable	=	58%
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Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
General Rule		
<p>1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.</p> <p style="text-align: right;">42 CFR §438.230(b)(1) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Magellan does not delegate • Provider Credentialing/Recertification Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process:		
<p>HSAG Findings: During the interview, Magellan confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.</p>		
Required Actions: No action required.		
Contract or Written Arrangement		
<p>2. Each contract or written arrangement with a delegate must specify:</p> <p>a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.</p> <p>b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE’s contract obligations.</p> <p>c. The contract or written arrangement must either provide for revocation of the delegation of activities or</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Magellan does not delegate. • Provider Credentialing/Recertification Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily.</p> <p style="text-align: right;">42 CFR §438.230(b)(2) 42 CFR §438.230(c)(1) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3 PAHP Contract: 2.15.6.3; 2.15.9 PIHP Contract: 1.5.3.1</p>		
MCE Description of Process:		
HSAG Findings: During the interview, the PIHP confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and</p> <p>MCO:</p> <p style="padding-left: 20px;">a. <i>rules, policies, procedures, manuals, the State Plan, and Waivers.</i></p> <p style="text-align: right;">42 CFR §438.230(c)(2) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not delegate. Provider Credentialing/Recredentialing Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process:		
HSAG Findings: During the interview, the PIHP confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>4. The contract or written arrangement indicates, and the delegate agrees that:</p> <p style="margin-left: 20px;">a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE’s contract with the State.</p> <p style="margin-left: 20px;">b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.</p> <p style="margin-left: 20px;">c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.</p> <p style="margin-left: 20px;">d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.230(c)(3) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not delegate. Provider Credentialing/Recredentialing Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCE Description of Process:		
HSAG Findings: During the interview, the PIHP confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
<p>5. The contract or written arrangement:</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.</i></p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.230 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template HSAG will also use the results from the Delegation File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not delegate. Provider Credentialing/Recredentialing Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
MCE Description of Process:		
HSAG Findings: During the interview, the PIHP confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Monitoring and Auditing		
<p>6. Monitoring subcontractor’s performance shall be monitored:</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Delegation agreement/contract template Monitoring and audit documentation Annual formal review HSAG will also use the results from the Delegation File Review 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>PAHP:</p> <p>a. <i>On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.</i></p> <p>PIHP:</p> <p>a. <i>The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.230 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not delegate. Provider Credentialing/Recertification Process CR.1107.06, pgs. 1-3, referencing section 3, pg. 3. 	
MCE Description of Process:		
HSAG Findings: During the interview, the PIHP confirmed that it does not delegate any managed care function, nor does it subcontract any contractual obligations to other entities; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	0	X	1	=	0
	Not Met	=	0	X	0	=	0
	Not Applicable	=	6				
Total Applicable		=	0	Total Score		=	NA

Total Score ÷ Total Applicable	=	NA
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Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
Adoption of Practice Guidelines		
<p>1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.</p> <p style="text-align: right;">42 CFR §438.236(b)(1) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Clinical Practice Guidelines Development and Review pg 2 • UM Program Policy pg 2 • APA CPG ADHD • APA CPG Depression and Conduct Disorder • APA CPG PTSD <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Screenshots of website for CPG 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: Magellan adopts guidelines based on APA standards.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>2. The MCE adopts practice guidelines that consider the needs of the MCE’s members and:</p> <p>MCO:</p> <p>a. adopts clinical practice guidelines for at least the conditions listed below:</p> <ul style="list-style-type: none"> i. Schizophrenia; ii. Attention Deficit Hyperactivity Disorder (ADHD); iii. Autism Spectrum Disorder; iv. Depression; v. Generalized Anxiety Disorder; vi. Post-Traumatic Stress Disorder; vii. Suicidal Behavior; viii. Oppositional Defiant Disorder; ix. Bipolar Disorder; and x. Substance Use Disorders. <p>PIHP:</p> <p>a. develops clinical practice guidelines for:</p> <ul style="list-style-type: none"> i. ADHD ii. Trauma Informed Care iii. Depression and Conduct Disorder <p style="text-align: right;">42 CFR §438.236(b)(2) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Clinical Practice Guidelines Development and Review pg 2 • UM Program Policy pg 2 • APA CPG ADHD • APA CPG Depression and Conduct Disorder • APA CPG PTSD 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: We have CPG’s for ADHD, PTSD, and Depression and Conduct Disorder.</p>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>3. The MCE adopts practice guidelines that are adopted in consultation with network providers.</p> <p style="text-align: right;">42 CFR §438.236(b)(3) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Clinical Practice Guidelines Development and Review pg 2 • UM Program Policy pg 2 • APA CPG ADHD • APA CPG Depression and Conduct Disorder • APA CPG PTSD • 20240617 MPTC Meeting Minutes Redacted • 20240924 MPTC Meeting Minutes Redacted • 20241210 MPTC Meeting Minutes Redacted 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Input from providers includes committees, customer organizations, Medical Directors, and feedback from providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>4. The MCE adopts practice guidelines that are:</p> <p>MCO/PAHP:</p> <p style="margin-left: 20px;">a. reviewed and updated periodically as appropriate.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. Reviewed annually and updated periodically as appropriate.</p> <p style="margin-left: 20px;">b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(b)(4) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract: 7.4.5.4; 7.4.7.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Clinical Practice Guidelines Development and Review pg 2 UM Program Policy pg 2 Benefit Certification Appeal General Guidelines pg 12 APA CPG ADHD APA CPG Depression and Conduct Disorder APA CPG PTSD 20240617 MPTC Meeting Minutes Redacted 20240924 MPTC Meeting Minutes Redacted 20241210 MPTC Meeting Minutes Redacted <p>Additional Documentation:</p> <ul style="list-style-type: none"> Created local policy to be approved. - Draft attached Clinical Practice Guidelines Policy 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
MCE Description of Process: CPG’s are reviewed when updates or changes are made.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Dissemination of Guidelines		
<p>5. The MCE disseminates the guidelines to:</p> <ul style="list-style-type: none"> a. All affected providers b. Members and potential members, upon request <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(c) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Clinical Practice Guidelines pg 3 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Screenshots of website for CPG 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: CPG’s are available on the websites and to members upon request.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
Application of Guidelines		
<p>6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p style="text-align: right;">42 CFR §438.236(d) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Coverage guidelines/criteria Member educational guidance (i.e., disease management) Member materials (i.e., member handbook, member newsletters) Three examples of coverage denial notices <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Created local policy to be approved. - Draft attached Clinical Practice Guidelines Policy We did not have any coverage denials for 2024 since we do not apply CPGs when making authorization decisions. 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: This does not apply to Magellan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan was unable to provide evidence of how it aligned the practice guidelines with UM, member education, and coverage of services, and how the guidelines were actually used consistently in decision-making per the federal requirement.</p>		
<p>Required Actions: The MCE must update or develop policies and procedures that demonstrate that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p>		



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Results for Standard X—Practice Guidelines					
Total	Met	=	5	X	1 = 5
	Not Met	=	1	X	0 = 0
	Not Applicable	=	0		
Total Applicable		=	6	Total Score	= 5

Total Score ÷ Total Applicable	=	83%
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Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
General Rule		
<p>1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to:</p> <ul style="list-style-type: none"> a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. <p style="text-align: right;">42 CFR §438.242(a) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSOC Data Collection and Integration Procedure – Section I - IV • System and Technical Requirements – Context Diagram • Current Discharge Reasons • Screenshot of disenrollment reasons 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	Additional Documentation: <ul style="list-style-type: none"> Legislative and Regulatory Tracking 	
<p>MCE Description of Process: The CSOC Data Collection and Integration Procedure states how Magellan complies with all reporting requirements, how we collect data, and how we maintain quality and integrity of our data. The System and Technical Requirements – Context Diagram provides what systems that Magellan utilizes and what data/information are processed between Magellan eco-systems.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Basic Elements of a Health Information System		
<p>2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State.</p> <p style="text-align: right;">42 CFR §438.242(b)(2) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Claims data collection and processing guidelines Encounter data collection and submission guidelines HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSOC Data Collection and Integration Procedure – Section I - IV EDI-Claims-Workflow High-Level-Encounters-Process-Flow Magellan Encounter Process Policy and Procedure 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The CSOC Data Collection and Integration Procedure states how Magellan complies with all reporting requirements, how we collect data, and how we maintain quality and integrity of our data. The Encounters Data Flow and Procedure explain how Magellan ensures compliance for Encounter submission, processing, and remediation.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The MCE ensures that data received from providers is accurate and complete by:</p> <ol style="list-style-type: none"> a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts. <p style="text-align: right;">42 CFR §438.242(b)(3) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines • Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Accuracy of Claims Processing Policy – Section I - VI • Timeliness of Claims Processing Policy – Section I – VI <p>Additional Documentation:</p> <ul style="list-style-type: none"> • 2024_CSOC_Claim_Timeliness 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: The Accuracy of Claims Processing Policy is to establish standards for calculating and measuring claims processing accuracy.</p>		



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
The Timeliness of Claims Processing Policy is to establish standards which meet all applicable regulatory and contractual standards for the timely processing and payment of claims.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>4. The MCE makes all collected data available to the State and upon request to CMS.</p> <p style="text-align: right;">42 CFR § 438.242(b)(4) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSOC Data Collection and Integration Procedure – Section I - IV 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The CSOC Data Collection and Integration Procedure states how Magellan complies with all reporting requirements, how we collect data, and how we maintain quality and integrity of our data.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Claims Processing		
<p>5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission).</p> <p style="text-align: right;">42 CFR §438.242(b)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies, procedures, and workflows • Claims data collection and processing guidelines • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1233(d)</p> <p>Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F) MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSOC Data Collection and Integration Procedure – Section I - IV Accuracy of Claims Processing Policy – Section I - VI Timeliness of Claims Processing Policy – Section I - VI 	
<p>MCE Description of Process: The CSOC Data Collection and Integration Procedure states how Magellan complies with all reporting requirements, how we collect data, and how we maintain quality and integrity of our data. The Accuracy of Claims Processing Policy is to establish standards for calculating and measuring claims processing accuracy. The Timeliness of Claims Processing Policy is to establish standards which meet all applicable regulatory and contractual standards for the timely processing and payment of claims.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Application Programming Interface		
<p>6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members’ personal representatives through the API as follows:</p> <p style="margin-left: 20px;">a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed;</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. List of registered third-party applications HSAG will use the results from the API demonstration 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments;</p> <p>c. All other encounter data, including adjudicated claims and encounter data from any subcontractors.</p> <p>d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE;</p> <p>e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information.</p> <p style="text-align: right;">42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> • API-Documents 	
MCE Description of Process:		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p> <p>Recommendations: HSAG recommends that Magellan prioritize continued Application Programming Interface (API) development as it is essential for not only enabling valuable business functions but also meeting federal regulatory requirements.</p>		
<p>Required Actions: No action required.</p>		



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR §431.60(d), and is accessible via a public-facing digital endpoint on the MCO’s website.</p> <p style="text-align: right;">42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d)</p> <p>MCO Contract: -2.13.2.3 PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6 PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. List of registered third-party applications HSAG will use the results from the web-based provider directory demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Network Provider Data Maintenance and Data Integrity Policy – Section I - III API documentation N/A List of registered third-party applications N/A <p>Additional Documentation:</p> <ul style="list-style-type: none"> API-Documents 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: The Network Provider Data Maintenance and Data Integrity Policy describes Magellan's policy and standards for collecting, entering, maintaining, and validating provider information in Magellan’s provider database.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Recommendations: HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p>Required Actions: No action required.</p>		



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
Member Encounter Data		
<p>8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.</p> <p style="text-align: right;">42 CFR §438.242(c)(1) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5 PIHP Contract: 15.2.2.3; 15.2.2.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Encounter data collection requirements Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan Encounter Process Policy and Procedure Samples of CSOC Encounters Data 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Magellan Encounter Process Policy and Procedure sets forth the standards used by Magellan to ensure compliance for Encounter submission, processing, and remediation.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs.</p> <p>a. The member encounter data includes all State-specific requirements for encounter data submissions, including</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies, procedures, and workflows Encounter data submission requirements Three concurrent months/quarters of submission compliance (acceptance/rejection reports) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818.</p> <p>b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.</p> <p>MCO:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH</i></p> <p>PAHP:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly.</i></p> <p>PIHP:</p> <p>a. <i>Submit complete and accurate encounter data at least weekly</i></p> <p style="text-align: right;">42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1</p>	<ul style="list-style-type: none"> Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source) HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan Encounter Process Policy and Procedure LA CSOC 2024 Encounters Acceptance Rates Samples of CSOC Encounters Data 	
<p>MCE Description of Process: Magellan Encounter Process Policy and Procedure sets forth the standards used by Magellan to ensure compliance for Encounter submission, processing, and remediation.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Results for Standard XI—Health Information Systems						
Total	Met	=	9	X	1	= 9
	Not Met	=	0	X	0	= 0
	Not Applicable	=	0			
Total Applicable		=	9	Total Score		= 9

Total Score ÷ Total Applicable	=	100%
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Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
General Rules		
<p>1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members.</p> <p style="text-align: right;">42 CFR §438.330(a)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, pp. 2–4, Policy Statement and Standards I–III, defines QI program authority, structure, description, and work plan. SXIII CSoC Program Description CY 2024, pp. 6–7 SXII CSoC QAPI Work Plan CY 2024, pp. 1–22 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan has established and implements an ongoing, comprehensive QAPI program for all services furnished to members, as detailed in the CSoC Quality Improvement Program Policy, Program Description, and Work Plan. The QAPI program aligns with federal and state requirements and includes defined governance, performance goals, stakeholder engagement, and continuous monitoring of quality activities.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
Basic Elements of QAPI Programs		
<p>2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services.</p> <p style="text-align: right;">42 CFR §438.330(b)(3) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, SXIII CSoC Program Description CY 2024, pp. 13 – 14, describes our approach to monitoring & p.36 -37 outlines the UMC charter. SXII CSoC QAPI Work Plan CY 2024, pp. 12, demonstrates how service utilization is monitored Program Evaluation (CY 2023); Pages: 100–111 (core); UMC Meeting Minutes Q1 – Q4 2024, provide evidence of monitoring of utilization of services. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version XII_CSoC QAPI Program Evaluation_2024.pdf XII_CSoC QAPI Program Evaluation_2024_Supplemental Reports UMC Meeting Minutes Q1 – Q4 2024, provide evidence of monitoring of utilization of services. 	
<p>MCE Description of Process: The QAPI program includes mechanisms to assess both underutilization and overutilization of services. These functions are integrated into Magellan’s monitoring structure and overseen by the Utilization Management Committee (UMC), as described in the CSoC Program Description and reflected in the QAPI Work Plan. UMC meeting minutes for all four quarters document regular review of utilization trends, supporting oversight and identification of service gaps or inefficiencies.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy.</p> <p style="text-align: right;">42 CFR §438.330(b)(4) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Definition of members with special health care needs Assessment tools Clinical guidance/criteria Metrics/performance measures to assess special health care needs 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, Addendum I, Section C.3 (p. 6) — Outlines mechanisms for monitoring both underutilization and overutilization, including review by standing committees and the development of strategies for improvement. SXIII CSoc QAPI Program Description CY 2024, pp. 13–14 — Describes Magellan’s structured approach to utilization monitoring, including definitions, thresholds, and data collection strategies; pp. 36–37 include the Utilization Management Committee (UMC) charter, detailing roles and responsibilities for overseeing appropriate service utilization. SXII CSoc QAPI Work Plan CY 2024, p. 12 — Includes a dedicated goal and objective related to over/underutilization, with specific action steps, responsible owners, and timelines. SXII CSoc QAPI Program Evaluation 2024, pp. 110–122 — Provides data analyses of utilization trends, including service types, patterns, and member-level indicators to identify gaps or excessive service use. UMC Meeting Minutes Q1–Q4 2024 — Document quarterly review of utilization patterns, identification of outliers, and discussion of mitigation strategies in response to under- or overutilization findings. 	



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	<ul style="list-style-type: none"> • Performance Measure Tracking from QAPI Work Plan and Evaluation — Measures such as Readmission Rates, Inpatient ALOS, Follow-up After Hospitalization, and Outpatient Utilization are used to monitor both service overuse and underuse. • Assessments and Tools <ul style="list-style-type: none"> – SXII R3. Clinical Procedures – POC Review Tool – POC Review Tool Coding Guide – Plan of Care Review Procedure – CSoC IBHA – CSoC CANS Rating Sheet <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Quality Improvement Program - QI.105.18 - 2024 version • XII_CSoC QAPI Program Evaluation_2024.pdf • XII_CSoC QAPI Program Evaluation_2024_Supplemental Reports • UMC Meeting Minutes Q1 – Q4 2024, provide evidence of monitoring of utilization of services. 	
<p>MCE Description of Process: The process for the QAPI program and the elements inclusive to the program for quality and appropriateness of how services are furnished to members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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<p>4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including:</p> <p style="margin-left: 20px;">a. Assessment of care between care settings; and</p> <p style="margin-left: 20px;">b. Comparison of services and supports received with those set forth in the member’s treatment/service plan, if applicable.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b)</p> <p>MCO Contract: NA PAHP Contract: None PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Assessment tools Clinical guidance/criteria Metrics/performance measures to assess LTSS Medical record audit tools and results <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> This does not apply to Magellan. 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p>MCE Description of Process: This does not apply to Magellan.</p>		
<p>HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
Performance Measurement		
<p>5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually:</p> <p style="margin-left: 20px;">a. Measures and reports to the State on its performance, using the standard measures required by the State;</p> <p style="margin-left: 20px;">b. Submits to the State data, specified by the State, which enables the State to calculate the MCO’s performance using the standard measures identified by the State; or</p> <p style="margin-left: 20px;">c. Performs a combination of the activities described in subelements (a) and (b).</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Performance measures reports Evidence of submission of performance measurement reports to the State 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, pp. 4–7, Standards III.B; Addendum I, D.1–3 Covers submission and tracking of state-defined measures.SXII Quality Improvement Program Policy • QM 01 _Louisiana CSoC QA PI Program Description_2024_LDH Approved_20240514.docx • QM 01 _CSoC QAPI Quality Work Plan_2025_Final Approved_20250528.docx • QM 02 _CSoC QAPI Program Evaluation_2024_LDH Approved 20250528.docx • CSoC FUH Report_2024_Resubmission_20250515.xlsb • CSoC _Annual Waiver Assurance Report_WY2 2024_20230701 - 20240630_Resubmission.docx • QM05 - Demographics_WY3 2025 Q2_Resubmission.xlsx • QM 17 _Improving POC Quality_Q4 2024_20250130_Resubmission_20250319.docx • QM09 - Living Situation at Discharge_WY3 2025 Q2_Resubmission_DRAFT.xlsx • CSoC _Data Collection & Integration_Pol_2025.pdf • CSoC Report Development_Quality Assurance Procedures_DP_20250202docx.docx 	



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	<p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version XII_CSoC QAPI Program Evaluation_2024.pdf XII_CSoC QAPI Program Evaluation_2024_Supplemental Reports 	
<p>MCE Description of Process: Magellan collects and analyzes data and submits performance reporting measures identified in the LDH’s Quality Improvement Strategy (QIS). Magellan conducts all required activities, including but not limited to:</p> <ul style="list-style-type: none"> Submitting a CAP within 30 calendar days of notification by the LDH, including a timetable for correcting performance deficiencies. All CAPs are subject to LDH approval, and progress is monitored until deficiencies are corrected. Providing the LDH with weekly reports of wraparound referrals and enrollment from the WAAs. Collecting WAA-submitted youth and caregiver data, including indicators related to natural supports, Out-of-Home placements, hospitalizations, discharge status, and other outcomes. This data is collected through the CSoC Wraparound Data Spreadsheet and validated through record reviews. Submitting quantitative reports with monthly, quarterly, and year-to-date results as directed by the LDH, accompanied by summaries and required narrative interpretation. Ensuring each submission includes methodology, such as data sources, sampling approach, and validation procedures, aligned with regulatory technical specifications. Adhering to all HIPAA, state, and federal data integrity standards in reporting processes, consistent with Magellan’s CSoC Data Collection and Integration Procedure (Approved 05/06/2024) and CSoC Report Development Quality Assurance Procedure (Approved 02/02/2025). Employing internal QA protocols to ensure accuracy and completeness of report content prior to submission. Reports follow standardized formatting, undergo formula and narrative review, and are tracked in the QI Reporting Master List. <p>Magellan also tracks measure-level performance within its QI Work Plan, aligning performance indicators with waiver deliverables, state-defined benchmarks, and scorecard domains. Examples include the Follow-Up After Hospitalization (FUH) rate, Living Situation at Discharge, and quarterly tracking of Plan of Care Quality using structured review tools. Reports include comparison to prior performance and root cause analysis when thresholds are not met.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Performance Improvement Projects		
<p>6. The QAPI program includes performance improvement projects (PIPs).</p> <p style="padding-left: 20px;">a. The MCE conducts PIPs that focus on both clinical and nonclinical areas.</p> <p>MCO:</p> <p style="padding-left: 20px;">a. <i>The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.</i></p> <p>PIHP:</p> <p style="padding-left: 20px;">a. The PIHP shall perform a minimum of one LDH approved PIP.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation List of all active PIPs, including which PIPs are considered clinical and non-clinical Documentation for all active PIPs <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, p. 7, Addendum I, E.1: References PIPs focused on clinical and nonclinical areas. SXII R.6 - 8 Magellan_LDH_PIP_CY 2023 to 2025 Remeasurement Year 1 2024, entire report, pp. 1 – 152 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version XII_CSoC QAPI Program Evaluation_2024.pdf XII_CSoC QAPI Program Evaluation_2024_Supplemental Reports Louisiana CsoC QIAs in 2024 Non-clinical <ul style="list-style-type: none"> – Plan of Care 06 – Waiver Service Needs – Plan of Care 04 - Quality Improvement Plan 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> • Clinical <ul style="list-style-type: none"> – Enhancing the Quality of Wraparound Care Plans Through Improved Incorporation of Evidence-Based Practices and Refinement of Strategies for the Child and Family Team – Follow-Up After Hospitalization (FUH) • Please see QIC meeting minutes for additional information. 	
<p>MCE Description of Process: The Quality Improvement Program Policy (p. 7, Addendum I, E.1) states that Magellan conducts PIPs focused on both clinical and nonclinical areas. During the review period, the MCE implemented multiple LDH-approved PIPs, as documented in the 2023–2025 PIP report. These include both clinical and nonclinical projects, meeting the federal and contractual requirements for PIHPs.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements:</p> <ol style="list-style-type: none"> a. Measurement of performance using objective quality indicators. b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. <p style="text-align: right; margin-right: 50px;">42 CFR §438.330(d)(2) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • QAPI program description • QAPI program work plan • QAPI program evaluation • Policies and procedures • Documentation for all active PIPs <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, pp. 7, Addendum I, E.2: Explicitly includes measurement, interventions, evaluation, and sustainability. • SXIII CSoc Program Description CY 2024, Scope of QI Program, Performance Improvement Projects, pp. 17. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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PIHP Contract: 12.5.3	<ul style="list-style-type: none"> • SXII R.6 - 8 Magellan_LDH PIP_CY 2023 to 2025_Remeasurement Year 1_2024, Step 7: Indicator Results. <ul style="list-style-type: none"> – SXII R.7.a. Step 5. Select the Performance Indicators, pp. 17 – 22. • Two examples of interventions are tagged in the PIP report to show MCE’s compliance with SXII R.7.b. – d using the HSAG template <i>Step 8. Intervention Worksheet</i>, <ul style="list-style-type: none"> – Example of Intervention #1, pp. 64 – 77 – Example of Intervention #2, pp. 78 – 80 • For SXII R.7.d. evidence of annual planning is provided. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Quality Improvement Program - QI.105.18 - 2024 version • XII_CSoC QAPI Program Evaluation_2024.pdf • XII_CSoC QAPI Program Evaluation_2024_Supplemental Reports • Magellan_LA2024_PIP_Remeasurement Year 1_20250627 (2024 final report uploaded), Conclusions and Next Steps, pp. 38 – 40. 	
MCE Description of Process: The process that involves the elements that are to be inclusive to the performance improvement plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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<p>8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year.</p> <p style="text-align: right;">42 CFR §438.330(d)(3) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Evidence of annual submission of all PIPs to the State <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, p. 7, Addendum I, E.3: Requires annual (at minimum) submission to LDH. SXII R.6 - 8 Magellan_LDH PIP_CY 2023 to 2025_Remeasurement Year 1_2024 <p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The elements of maintaining and upholding to tracking and reporting for the performance improvement plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Critical Incidents		
<p>9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h).</p> <p style="text-align: right;">42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI program description QAPI program work plan QAPI program evaluation Three examples of critical incident reports Committee meeting minutes Provider remediation plan template(s) 	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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<p>MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2</p>	<p style="text-align: center;">42 CFR §457.1240(b)</p> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, p. 6, Addendum I, C.5.b Links to waiver-based health and welfare protections. • SXII Quality Improvement Program Policy, p. 6, Addendum I, C.5.b – Defines health and welfare protections in accordance with waiver requirements. • SXIII CSoc Program Description CY 2024, pp. 19–21 – Describes Magellan’s approach to monitoring critical incidents within the broader care coordination framework. • SXII CSoc QAPI Work Plan CY 2024, pp. 14, 20 – Identifies oversight actions and monthly reporting timelines for adverse incidents. • QM 02_CSoc QAPI Program Evaluation_2024_LDH Approved_20250528 – Summarizes trends, sentinel event tracking, and improvement actions related to critical incidents. • QM 20_CSoc Adverse Incident Report_November 2024 – Monthly tracking of incident types and outcomes; Tab 8 includes active CAPs and remediation actions. • Quality of Care Concern Report_May 2024_6.14.24 – Trending tool for provider-level concerns; includes sentinel events and formal remediation monitoring. • LA CSoc_DP – Checklist_Provider Performance Inquiry Review Sentinel Events – 	



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	Internal documentation and decision tool for assessing sentinel events and triggering reviews.	
<p>MCE Description of Process: Magellan actively participates in LDH-directed efforts to prevent, detect, and remediate critical incidents, in alignment with federal requirements and waiver assurances. As outlined in the Quality Improvement Program Policy (p. 6, Addendum I, C.5.b), Magellan’s QAPI framework includes health and welfare protections consistent with 42 CFR §441.302 and §441.730(a). Critical incidents are monitored through structured reporting, trending, and root cause analysis processes embedded in monthly reports and QOCC oversight. Magellan collects and analyzes data on adverse incidents, including those submitted through the Provider Performance Inquiry (PPI) process. Sentinel events and serious trends are escalated to internal quality workgroups for formal review. Remediation plans, when warranted, are developed and tracked in alignment with contractual requirements, using tools such as the Quality of Care Concern (QOCC) report and the monthly Adverse Incident Report. Committee oversight is documented and includes review of incident patterns, provider follow-up, and CAPs where systemic issues are identified.</p>		
<p>HSAG Findings: Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p>Required Actions: No action required.</p>		
QAPI Program Reviews, Analysis, and Evaluation		
<p>10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:</p> <ul style="list-style-type: none"> a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. <i>The results of any efforts to support community integration for members using LTSS.</i> <p>MCO:</p> <ul style="list-style-type: none"> a. <i>The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.</i> <p style="text-align: right;">42 CFR §438.330(e) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Committee meeting minutes (with discussion of QAPI evaluation) <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, pp. 4–5 and 7, Standards III.B; V.D; Addendum I, F Covers trended data, effectiveness analysis, and Board review. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Quality Improvement Program - QI.105.18 - 2024 version • XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q1 2024 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4	<ul style="list-style-type: none"> XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q2 2024 XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q3 2024 XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q4 2024 	
MCE Description of Process: The elements of maintaining and upholding to tracking and reporting for the QAPI program and outcomes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. QAPI Committee Requirements: MCO: a. <i>The MCO forms a QAPI Committee that at a minimum includes:</i> <ol style="list-style-type: none"> <i>The MCO's Medical Director who must serve as either the chairman or co-chairman;</i> <i>The MCO's Behavioral Health Director;</i> <i>Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;</i> <i>Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and</i> <i>An Enrollee representative(s) and/or advocate(s).</i> PAHP: a. <i>The PAHP shall form a QAPI Committee that shall, at a minimum include:</i> <ol style="list-style-type: none"> <i>The Dental Director who must serve as either the chairman or co-chairman;</i> 	HSAG Required Evidence: <ul style="list-style-type: none"> QAPI committee meeting minutes Evidence as Submitted by the MCE: <ul style="list-style-type: none"> SXII Quality Improvement Program Policy, p. 5, Standard IV: Identifies QIC roles, responsibilities, and practitioner involvement. <i>SXII Program Description</i>, Appendix 4 (QIC Charter, pp. 29–43): Describes QIC membership, including Medical Director (Chair), Compliance Officer, Grievance/Appeal staff, and departmental representation across QI, Network, UM/CM, Member Services, and PI. Additional Documentation: <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>ii. <i>Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and</i></p> <p>iii. <i>The PAHP shall include an enrollee advocate representative on the QAPI Committee.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall form a QAPI committee that shall, at a minimum include:</i></p> <p style="margin-left: 20px;">i. <i>The PIHP’s Medical Director, who must serve as the chair or co-chair and</i></p> <p style="margin-left: 20px;">ii. <i>Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.</i></p> <p>MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1</p>	<ul style="list-style-type: none"> XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q1 2024 XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q2 2024 XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q3 2024 XII.10 & 11_Louisiana CSoC QIC Meeting Minutes_Q4 2024 	
MCE Description of Process: The process that includes the elements that are to be inclusive for the QAPI committee.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>12. QAPI Committee Responsibilities:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:</i></p> <p style="margin-left: 20px;">i. <i>Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures QAPI committee meeting minutes Evidence of submission to the State Evidence of working with other Contractor staff and Subcontractors Evidence of updates to the Provider Manual 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<ul style="list-style-type: none"> ii. <i>Ensure that QAPI activities take place throughout the MCO’s organization and ensure that providers are involved in the QAPI Program;</i> iii. <i>Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;</i> iv. <i>Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;</i> v. <i>Designate evaluation and study design procedures;</i> vi. <i>Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;</i> vii. <i>Report findings to appropriate executive authority, staff, and departments within the MCO’s organization;</i> viii. <i>Direct and analyze periodic reviews of Enrollees’ service utilization patterns;</i> ix. <i>Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;</i> x. <i>Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;</i> 	<ul style="list-style-type: none"> • Evidence of provider network performance reviews • Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members’ service utilization patterns <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, pp. 5–6, Standards IV–V: Matches LDH contract language on tasks and outputs. • SXII Quality Improvement Program Policy, pp. 5–6, Standards IV–V: Aligns with required QIC responsibilities per contract. • SXII Program Description, Appendix 4 (QIC Charter): Documents meeting cadence, functions, and committee structure with references to task forces and subcommittees. • UMC Meeting Minutes: June 2024, Sept 2024, Nov 2024, Feb 2025 – include documentation of provider profiling and utilization review. • SXII QAPI Provider Handbook, pp. 30–33: Describes provider profiling, updates, and roles. • Submission to LDH documented through monthly QI submissions and MOR reports (see MOR April–July 2024). <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Quality Improvement Program - QI.105.18 - 2024 version 	



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<p>xi. <i>Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;</i></p> <p>xii. <i>Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and</i></p> <p>xiii. <i>Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.</i></p> <p>PAHP:</p> <p>a. <i>The QAPI Committee shall:</i></p> <p style="margin-left: 20px;">i. <i>Meet on a quarterly basis;</i></p> <p style="margin-left: 20px;">ii. <i>Direct and review quality improvement (QI) activities;</i></p> <p style="margin-left: 20px;">iii. <i>Ensure that QAPI activities are implemented throughout the PAHP;</i></p> <p style="margin-left: 20px;">iv. <i>Review and suggest new and/or improved QI activities;</i></p> <p style="margin-left: 20px;">v. <i>Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;</i></p> <p style="margin-left: 20px;">vi. <i>Designate evaluation and study design procedures;</i></p> <p style="margin-left: 20px;">vii. <i>Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;</i></p> <p style="margin-left: 20px;">viii. <i>Report findings to appropriate executive authority, staff, and departments within the PAHP;</i></p>	<ul style="list-style-type: none"> UMC Meeting Minutes Q1 – Q4 2024, provide evidence of monitoring of utilization of services. XII.12_Secured1 FW_CSoC QIC Meeting Minutes – Q1 2024.pdf XII.12_Secured1 FW_CSoC QIC Meeting Minutes – Q2 2024.pdf XII.12_Secured1 FW_CSoC QIC Meeting Minutes - Q3 2024.pdf XII.12_Secured1 FW_CSoC QIC Meeting Minutes – Q4 2024 	



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<ul style="list-style-type: none"> ix. <i>Direct and analyze periodic reviews of enrollees' service utilization patterns;</i> x. <i>Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and</i> xi. <i>Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.</i> <p>PIHP:</p> <ul style="list-style-type: none"> a. <i>QAPI committee responsibilities shall include:</i> <ul style="list-style-type: none"> i. <i>Directing and reviewing QI activities;</i> ii. <i>Ensuring that QAPI activities take place throughout the organization;</i> iii. <i>Suggesting new and/or improved QI activities;</i> iv. <i>Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;</i> v. <i>Conducting provider quality performance measure profiling;</i> vi. <i>Reporting findings to appropriate executive authority, staff, and departments within the PIHP;</i> vii. <i>Directing and analyzing periodic reviews of members' service utilization patterns; and</i> viii. <i>Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.</i> 		



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Requirement	Supporting Documentation	Score
MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2		
MCE Description of Process: The process that includes the elements that are to be inclusive for the QAPI committee and timeframes established by Magellan and the state partner for the committee to join for meetings to report on topics driving towards specific outcomes for success.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>13. QAPI Plan Requirements:</p> <p>MCO:</p> <ol style="list-style-type: none"> a. <i>The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.</i> b. <i>The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.</i> c. <i>The QAPI Plan, at a minimum, shall:</i> <ol style="list-style-type: none"> i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i> ii. <i>Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;</i> iii. <i>Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;</i> iv. <i>Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • QAPI Plan • Evidence of submission to the State <p>Evidence Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXII Quality Improvement Program Policy, pp. 3–4 and 6–8, Standards III.A; Addendum I, C–F: Includes QAPI description, evaluation, staff roles, provider/member engagement, fidelity expectations, and compliance with CSoC-specific metrics. • SXIII CSoC Program Description CY 2024, pp. 4–5, 11, 13, 15, 24, 27, 35: Describes how the QAPI program is exclusive to CSoC, aligns with governing direction, and includes planning, evaluation, and use of demographic data for disparity reduction. • SXII CSoC QAPI Quality Work Plan CY 2024, pg. 11: Details annual objectives and action steps, including wraparound agency monitoring metrics and fidelity activities. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>v. <i>Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and</i></p> <p>vi. <i>Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.</i></p> <p>PAHP:</p> <p>a. <i>The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.</i></p> <p>b. <i>The QAPI plan shall be submitted to LDH annually, and prior to revisions.</i></p> <p>c. <i>The QAPI plan, at a minimum, shall:</i></p> <p style="margin-left: 20px;">i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i></p> <p style="margin-left: 20px;">ii. <i>Include processes to evaluate the impact and effectiveness of the QAPI Program;</i></p> <p style="margin-left: 20px;">iii. <i>Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and</i></p> <p style="margin-left: 20px;">iv. <i>Describe the role of providers in giving input to the QAPI Program.</i></p> <p>PIHP:</p> <p>a. <i>The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed</i></p>	<ul style="list-style-type: none"> SXII R12 QAPI Provider Handbook, pp. 30–33: Reflects dissemination of QAPI priorities to providers and integration into practice. SXII_Fidelity Report_Evidence of Submission to State_2024: Demonstrates timely LDH submission of QAPI deliverables. SXII R13.c. QM 15_Fidelity Survey Report_2024_LDH Approval_20250428.pdf: Plan of Care Review Tool Design, p. 4: Describes use of standardized tool aligned to NWI fidelity domains. Methodology section: Specifies sampling approach, exclusion logic, and representativeness. WAA Scorecard WY2Q4_20240815.pdf: Provides metrics and benchmarks used to track agency-specific performance and continuous improvement. CSoc WAA PBP Scorecard_Q2 2024_Full Details_20240816.pdf: Includes performance metrics tied to fidelity and service access used for pay-for-performance initiatives. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Quality Improvement Program - QI.105.18 - 2024 version 	



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Requirement	Supporting Documentation	Score
<p><i>Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of Behavioral Health, Louisiana Department of Health (OBH).</i></p> <p>b. <i>The QAPI program description at a minimum, shall:</i></p> <ul style="list-style-type: none"> i. <i>Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.</i> ii. <i>Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.</i> iii. <i>Specify the remediation actions that will be implemented when system performance is less than the required threshold.</i> iv. <i>Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention’s effectiveness.</i> v. <i>Describe how the Contractor will obtain feedback from providers and members.</i> vi. <i>Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.</i> vii. <i>Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain</i> 		



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Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>documentation from other state Medicaid programs or product lines operated by the Contractor.</i></p> <p>c. <i>The QAPI work plan at a minimum shall:</i></p> <p style="padding-left: 20px;"><i>Include objectives for the Contract year, inclusive of associated action steps and timelines.</i></p> <p style="padding-left: 40px;">i. <i>Include metrics and associated benchmarks for the</i></p> <p style="padding-left: 40px;">ii. <i>Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of UMactice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.</i></p> <p style="padding-left: 40px;">iii. <i>Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator's (WF) demonstration of established wraparound competencies on a quarterly basis.</i></p> <p>MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3</p>		



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Magellan has implemented a written Quality Assessment and Performance Improvement (QAPI) Program exclusive to the Louisiana Coordinated System of Care (CSoC), aligned with federal requirements and the PIHP contract. The QAPI Program Description and Quality Work Plan outline a coordinated strategy for planning, intervention, and evaluation of outcomes, and were submitted to LDH within the required timeframes. Staff roles, responsibilities, and organizational structure are defined in the QAPI Policy (pp. 3–4, 6–8) and Program Description (pp. 4–5, 13), with QI responsibilities integrated across departments and described in Standard III.A and Addendum I. The Program Description also explains how Magellan gathers feedback from providers and members (pp. 24, 27) and details its approach to using demographic data (race, ethnicity, language, geography, etc.) to identify and address health disparities (pp. 15, 35). The Quality Work Plan (pg. 11) sets annual objectives, timelines, and specific benchmarks for wraparound agency performance, tracked in the WAA Scorecard and CSOC Pay-for-Performance Scorecard. Fidelity monitoring is conducted annually using a standardized tool aligned with the National Wraparound Initiative (NWI), with methods and sampling criteria described in the QM15 Fidelity Survey Report and the Plan of Care Review Tool design. All fidelity and performance monitoring reports were submitted to LDH as required, as evidenced by SXII_Fidelity Report_Evidence of Submission to State_2024.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		

Results for Standard XII—Quality Assessment and Performance Improvement							
Total	Met	=	11	X	1	=	11
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	11	Total Score		=	11

Total Score ÷ Total Applicable	=	100%
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Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Grievance System General Requirements		
<p>1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 18-19 "Grievances" • SXIII. CSoC Medicaid Enrollee Grievances Policy, Section "Definitions," p. 2. Aligns with CFR examples. 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan defines a grievance as any expression of dissatisfaction about matters not related to an adverse benefit determination (ABD), including concerns related to the quality of services or provider conduct. This definition aligns with 42 CFR §438.400(b) and includes a member's right to dispute proposed extensions for authorization decisions. The definition is provided in both the member handbook and grievance policy to ensure clarity for members and staff.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>2. A member may file a grievance with the MCE at any time.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Member consent form template HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 18 “Grievances” and “Can someone else file a grievance for me?” SXIII. CSoC Medicaid Enrollee Grievances Policy, Section “Filing a Grievance,” p. 4. States that an enrollee may file at any time 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Members may file a grievance at any time. With written consent, a provider or authorized representative may also submit a grievance on behalf of the member. This flexibility is stated in both the member handbook and internal policy to support member access and representation.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>3. The member may file a grievance either orally or in writing.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook HSAG will also use the results of the system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 18 “Contact Magellan” 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> SXIII. CSoC Medicaid Enrollee Grievances Policy, Section “Filing a Grievance,” p. 4. States grievances may be submitted orally or in writing. 	
<p>MCE Description of Process: Grievances may be submitted orally or in writing. Oral grievances are documented by Magellan staff, and written grievances may be submitted by mail, email, or fax. This information is communicated in the member handbook and incorporated into internal policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Handling of Grievances		
<p>4. The MCE acknowledges receipt of each grievance.</p> <p>MCO and PAHP:</p> <p>a. <i>The MCO’s/PAHP’s process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.</i></p> <p>PIHP:</p> <p>a. <i>Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Grievance acknowledgment notice template Tracking and reporting mechanisms HSAG will also use the results of the Grievances File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII R4a CSoC Grievance Acknowledgement Letter SXIII. CSoC Medicaid Enrollee Grievances Policy, Section Under Section B.1 of "Handling A Grievance" on page 3 of the CSoC Medicaid Member Grievances Policy Includes 3-day written acknowledgment with same-day resolution exception. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Magellan acknowledges all grievances in writing within 3 business days unless the grievance is resolved on the same day. The acknowledgement process follows 42 CFR §438.406(b)(1) and includes member-specific details and support contact information.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>5. The MCE ensures that the individuals who make decisions on grievances are individuals:</p> <ul style="list-style-type: none"> a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease: <ul style="list-style-type: none"> i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. <p style="text-align: right; margin-right: 50px;"> 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d) </p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. CSoC Medicaid Enrollee Grievances Policy, Section B.3 of "Handling a Grievance" p. 4 states grievance reviewers must meet impartiality criteria. • SXIII. CSoC Medicaid Enrollee Grievances Policy, Section B.3.a of "Handling a Grievance" on page 4. Policy Reviewer cannot have participated in prior level or be a subordinate. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • XIII_G&A Files_Reviewer Qualifications.pdf • XIII_G&A Files_CSoC SXIII CSoC QAPI Program Description CY 2024, Appendix 3. QI Job Descriptions, pp. 27 -33 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process for how grievances are upheld, maintained and handled by the health plan for members.</p>		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Timely Resolution and Notification of Grievances		
<p>6. The MCE resolves each grievance, and provides notice, as expeditiously as the member’s health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408.</p> <p>MCO and PAHP Standard Grievances</p> <p>a. <i>The MCO/PAHP shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) Calendar Days from the date the MCO/PAHP receives the grievance.</i></p> <p>PIHP Standard Grievances</p> <p>a. <i>For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12)</p> <p>MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. Section III.A.1. of CSoc Medicaid Member Grievances Policy," Requirements of Resolution" on pg 5. Aligns with PHIP requirement for resolution and notice within 30 calendar days. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Grievances are resolved within 30 calendar days of receipt unless resolved more quickly based on the urgency of the member’s condition. Resolution notices include a summary of findings and any actions taken. The process aligns with PIHP contract requirements and 42 CFR §438.408.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking and reporting mechanisms Two examples of a grievance with extensions with LDH approval HSAG will use the Universe File to evaluate timeliness HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII. CSoc Medicaid Enrollee Grievances Policy, Section “Extension of Timeframe,” p. 5. Permits extension if requested by member. <p>Additional Documentation:</p> <ul style="list-style-type: none"> XIII.7 & 8_Magellan Medicaid Enrollee Grievances - MR.MCD.403.06 - Policy.pdf, Standard 1.I, pp. 4 (Please see page 8 for corporate policy life history and XIII.7 & 8_Medicaid Enrollee Grievances_Evidence of 2024 Policy Review.) 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: Magellan allows for an extension of up to 14 calendar days for grievance resolution if requested by the member or if the MCE can demonstrate that the delay is in the member’s best interest. No extensions were taken during the review period.		



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Requirement	Supporting Documentation	Score
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policy did not include the requirements of this element.</p>		
<p>Required Actions: The MCE must update polices and any applicable documents to include the process that the MCE may extend the time frame for resolving grievances by up to 14 calendar days if:</p> <ol style="list-style-type: none"> a. The member requests the extension; or b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest. 		
<p>8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following:</p> <ol style="list-style-type: none"> a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. <p style="text-align: right; margin-right: 50px;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Grievance extension template letter • Two examples of grievances with extensions with oral and written notice • HSAG will also use the results of the Grievances File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. CSoC Medicaid Enrollee Grievances Policy, Section “Extension of Timeframe,” p. 5. Permits extension if requested by member. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • XIII.7 & 8_Magellan Medicaid Enrollee Grievances - MR.MCD.403.06 - Policy.pdf, Standard 1.I, pp. 4 (Please see page 8 for corporate policy life history and XIII.7 & 8_Medicaid Enrollee Grievances_Evidence of 2024 Policy Review.) 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: If Magellan were to extend the grievance timeframe without a member request, prompt oral notice would be provided, followed by written notice within two calendar days explaining the reason and the member’s right to file a grievance. This process is defined in policy, although no such extensions occurred during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policies and procedures did not include that if the MCE extends the grievance resolution time frame not at the request of the member, it completes all of the following:</p> <ol style="list-style-type: none"> a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 		
<p>Required Actions: The MCE must revise its policies and procedures to include the requirement that if the MCE extends the grievance resolution time frame not at the request of the member, it completes all of the following:</p> <ol style="list-style-type: none"> a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. 		
Appeals General Requirements		
<p>9. The MCE defines an appeal as a review by the MCE of an ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • XIII R9 Provider Handbook • XIII R9 New Provider Orientation • CSoC Member Handbook p. 42 “Dictionary” 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process how an appeal is identified, upheld, maintained and handled by the health plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>10. The MCE has only one level of appeal for members.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Sample Inpatient Denial Letter Template 	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p>MCE Description of Process: An appeal is defined as a member’s request for review of an adverse benefit determination (ABD). This definition is consistently presented in provider training and the member handbook to ensure shared understanding.</p>		
<p>HSAG Findings: During the compliance review, HSAG identified that LDH’s contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since State requirements differ from federal requirements. HSAG has communicated this information to LDH.</p>		
<p>Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		
<p>11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.</p> <p>a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 21 “What if you need a fast decision?” • Sample Inpatient Denial Letter Template 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1		
MCE Description of Process: The process on how the expedited review for appeals is upheld, maintained and handled by the health plan for members.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking mechanisms Member materials, such as the member handbook ABD notice template Provider materials, such as the provider manual <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook pg. 20, sections 1-3, “Appeal and State Fair Hearing Procedures for Eligibility”. XIII R9 New Provider Orientation slide 38 XIII R9 Provider Handbook pg48-51 Sample Inpatient Denial Letter Template 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The process of how the member rights are established for timeframes on filing an appeal after the Adverse Benefit Determination has occurred.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>13. The member may file an appeal orally or in writing.</p> <p style="margin-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook Member consent form template HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p. 21 “How do you ask for an appeal?” 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: The process of how the members’ rights are established when the member consents orally or written to have an authorized representative to request an appeal on their behalf.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The file review of sample appeals showed several files did not include written consent from the member.</p>		
<p>Required Actions: The MCE must obtain written consent from the member for appeals that are requested by a provider or an authorized representative on behalf of the member.</p>		
Handling of Appeals		
<p>14. If the MCE denies a request for expedited resolution of an appeal, it:</p> <p style="margin-left: 20px;">a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).</p> <p style="margin-left: 20px;">b. Follows the requirements in 42 CFR §438.408(c)(2), including:</p> <p style="margin-left: 40px;">i. Makes reasonable efforts to give the member prompt oral notice of the delay.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Denied expedited resolution letter template HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2) 42 CFR §438.410(c) 42 CFR §457.1260(f)</p> <p>MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2</p>	<ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.AD.8, p. 11. Reasonable efforts to provide oral notice. Sample Inpatient Denial Letter Template 	
<p>MCE Description of Process: The process of how the health plan maintains and upholds to established timeframes on member notifications for appeals.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>15. The MCE acknowledges receipt of each appeal.</p> <p>MCO and PAHP:</p> <p>a. <i>The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.</i></p> <p>PIHP:</p> <p>a. Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Appeal acknowledgment template Tracking and reporting mechanisms HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.2, p. 5. Specifies appeals must be acknowledged. 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1</p>	<ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section II.D.2, p. 9. Aligns with PHIP 3-day acknowledgment rule. <p>Additional Documentation:</p> <ul style="list-style-type: none"> SXIII. CSoC Medicaid Enrollee Grievances Policy, Standard II.B.1, pp. 3 	
<p>MCE Description of Process: The process of how the health plan maintains and upholds to established timeframes on member notifications regarding acknowledgement of appeals from the member by the health plan.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policy stated that a written acknowledgement of the filing of all standard adverse benefit determination appeals is sent to the appealing party within 15 calendar days of such filing. LDH requires the PIHP to acknowledge receipt of each appeal in writing within three business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Case files reviewed did not consistently include a member acknowledgement notice.</p>		
<p>Required Actions: The MCE must revise its policy and procedure to acknowledge receipt of each appeal in writing within three business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received.</p>		
<p>16. The MCE ensures that the individuals who made decisions on appeals are individuals:</p> <p>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</p> <p>b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Organizational chart of appeal staff members, including credentials HSAG will also use the results of the Appeals File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>i. An appeal of a denial that is based on lack of medical necessity.</p> <p>ii. An appeal that involves clinical issues.</p> <p>c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section II.G.3, p. 5. Outlines impartiality standards. SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section II.B.3a, p. 5. Prohibits prior reviewers from appeal decisions. SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.3.i, p. 5. Requires appropriate clinical expertise. SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.4, p. 10. Includes all submitted information. <p>Additional Documentation:</p> <ul style="list-style-type: none"> XIII_G&A Files_Reviewer Qualifications.pdf XIII_G&A Files_CSoC SXIII CSOC QAPI Program Description CY 2024, Appendix 3. QI Job Descriptions, pp. 27 -33 	
<p>MCE Description of Process: The process of how the health plan maintains and upholds to decisions made for appeals for members.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>17. The MCE treats oral inquiries seeking to appeal an ABD as appeals.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) 17</p> <p>MCO Contract: None</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Member materials, such as the member handbook HSAG will also use the results of the Appeals File Review 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> CSoC Member Handbook p. 21 “How do you ask for an appeal?” SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.4, p. 6. Oral inquiries initiate appeal process. 	
MCE Description of Process: The process the health plan upholds and maintains to for oral inquiries for adverse benefit determination after an appeal has occurred.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution. <div style="text-align: right;"> 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) </div> MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Member communications, such as ABD notice template, member acknowledgment template, and/or call script HSAG will also use the results of the Appeals File Review Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Sample Inpatient Denial Letter Template SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.6, p. 6. Member may present evidence in writing or in person. SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section II.B.6, p. 13. Member notified of timeframe. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: The process the health plan upholds and maintains to for oral inquiries for adverse benefit determination after an appeal has occurred and outcomes for members seeking inquiries.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD.</p> <p>a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c). MCO and PAHP:</p> <p>a. <i>Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Sample Inpatient Denial Letter Template • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.G.7, p. 6. Ensures member access to case file. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3</p>		
<p>MCE Description of Process: The process the health plan upholds and maintains on the use and disclosure for appeals after the adverse benefit determination has occurred.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Resolution and Notification of Appeals		
<p>20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member’s health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking documentation • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.B.6, p. 12. 30-day resolution for standard appeals. 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan resolves standard appeals within 30 calendar days from the date the appeal is received, in accordance with 42 CFR §438.408. All decisions are documented and shared in writing with the member or authorized representative.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.A.7, p. 10. 72-hour resolution for expedited appeals. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Expedited appeals are resolved within 72 hours of receipt when the request meets urgency criteria. Magellan monitors timeliness through tracking systems and ensures notice is issued promptly, per federal and state requirements.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if:</p> <p style="padding-left: 20px;">a. The member requests the extension; or</p> <p style="padding-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.A.10, p. 11-12. Outlines extension conditions. 	
MCE Description of Process: Magellan permits a 14-day extension of the appeal resolution timeframe if requested by the member or if the plan demonstrates that additional time is needed in the member’s interest. No extensions were taken during the review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following: <ol style="list-style-type: none"> Makes reasonable efforts to give the member prompt oral notice of the delay. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision. Resolves the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires. <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2)</p> MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Two examples of appeals with extended time frame with oral and written notice appeal extension template letter HSAG will also use the results of the Appeals File Review 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section II.E.1-2, a-h, p. 9. Meets federal extension standards. 	



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: When the MCE extends an appeal timeframe without a member’s request, staff provide prompt oral notice and written notification within two calendar days explaining the reason and informing the member of their right to file a grievance. This protocol is detailed in internal policy. No such extensions occurred during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE’s appeals process. The member may initiate a State fair hearing (SFH).</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoc Member Handbook p.22 “If you do not agree with what happened...” • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.B.1, p. 4. Acknowledges member deems appeal process exhausted if MCE fails timeline requirements. 		
<p>MCE Description of Process: If Magellan fails to adhere to required timeframes for resolving an appeal, the member is considered to have exhausted the internal appeals process and may request a State Fair Hearing. This information is stated in both internal policy and the member handbook.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>25. For all appeals, the MCE provides written notice of the appeal resolution that includes:</p> <ol style="list-style-type: none"> a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: <ol style="list-style-type: none"> i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request. iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal. <p>MCO:</p> <ol style="list-style-type: none"> a. <i>The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.</i> b. <i>The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.</i> c. <i>For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the enrollee of their right to seek a State Fair Hearing if the enrollee is not satisfied with</i> 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section I.R.2, p. 7. Resolution notice includes outcome and date. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><i>the MCO’s decision in response to an appeal, and the process for doing so.</i></p> <p>PAHP:</p> <ul style="list-style-type: none"> a. <i>The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.</i> b. <i>The PAHP shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.</i> c. <i>The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP’s decision in response to an appeal, and the process for doing so.</i> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4)</p> <p>MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13</p>		
<p>MCE Description of Process: Written notices of appeal resolution include the outcome, the date of resolution, and, if not resolved fully in the member’s favor, instructions for requesting a State Fair Hearing, continuation of benefits, and applicable financial responsibility. These requirements are detailed in Magellan policy and templates.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice. MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.AD.8, p. 11. Reasonable efforts to provide oral notice. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: When an expedited appeal is resolved, Magellan makes reasonable efforts to notify the member orally on the day of the decision and follows up with a written notice within two calendar days, per policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
State Fair Hearings and State External Review		
<p>27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal.</p> <p style="margin-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5)</p> <p>Contract H.4.03</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Appeal resolution notice template Member materials, such as the member handbook and/or ABD notice <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p.22 “If you do not agree with what happened...” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCO Contract: 2.15.1.11; 2.15.4.1 PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2	<ul style="list-style-type: none"> Sample Inpatient Denial Letter Template SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.C.1-3, p. 13. SFH request follows MCE upholding of ABD. 	
<p>MCE Description of Process: Members may request a State Fair Hearing after receiving an appeal resolution upholding the adverse benefit determination. With member consent, a provider or authorized representative may request the hearing on the member’s behalf. This process is outlined in policy, member notices, and communications.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>28. The member has <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p> <p>MCO:</p> <p>a. <i>An enrollee or other party to the appeal, who has completed the MCO’s appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p>PAHP:</p> <p>a. <i>An enrollee or authorized representative, who has completed the PAHP’s appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in whole or in part, the adverse benefit determination, or</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Appeal resolution notice template Member materials, such as the member handbook and/or ABD notice HSAG will also use the results of the Appeals File Review <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> CSoC Member Handbook p.22 “If you do not agree with what happened...” Sample Inpatient Denial Letter Template SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.C.3, p. 13. Members have 120 days from MCE’s notice. 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>after the PAHP fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p>PIHP:</p> <p>a. <i>The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP's notice of resolution.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> SXIII. Medicaid ABD Appeal Policy, Standard III.C.2. pp. 13 	
<p>MCE Description of Process: Magellan continues benefits during an appeal when: (1) the request is made timely, (2) services were previously authorized, (3) the provider is authorized, (4) the authorization period has not expired, and (5) continuation is specifically requested. These criteria are outlined in policy and member notices. No continuation cases occurred during the review period.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policy stated that the enrollee must have no less than ninety (90) calendar days and no more than one hundred and twenty (120) calendar days from the date of Magellan’s notice of appeal resolution to request a State Fair Hearing (SFH). LDH requires that the MCE provide the member <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p>		
<p>Required Actions: The MCE must revise its policy and procedure to provide the member <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p>		



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Requirement	Supporting Documentation	Score
Continuation of Benefits		
<p>29. The MCE continues the member’s benefits if all of the following occur:</p> <ul style="list-style-type: none"> a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits. <p>MCO/PAHP/PIHP:</p> <ul style="list-style-type: none"> a. <i>Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.</i> <p><i>Timely files</i> means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE’s proposed ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(a-b)</p> <p>MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Sample Inpatient Denial Letter Template • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.C.4.a-e, p. 13-14. Lists all required continuation conditions. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Magellan continues benefits during an appeal when: (1) the request is made timely, (2) services were previously authorized, (3) the provider is authorized, (4) the authorization period has not expired, and (5) continuation is specifically requested. These criteria are outlined in policy and member notices. No continuation cases occurred during the review period.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>30. If, at the member’s request, the MCE continues or reinstates the member’s benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs:</p> <p>a. The member withdraws the appeal or request for SFH.</p> <p>b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member’s appeal.</p> <p>c. A SFH office issues a hearing decision adverse to the member.</p> <p>MCO and PAHP:</p> <p>a. Appeals</p> <p style="margin-left: 20px;">i. <i>The time period or service limits of a previously authorized service has been met.</i></p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.228 42 CFR §438.420(c)</p> <p>MCO Contract: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures ABD notice template HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Sample Inpatient Denial Letter Template SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.C.4.d.i-iii, p. 13-14. Benefits must continue until condition is met. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
MCE Description of Process: Magellan continues benefits during an appeal when: (1) the request is made timely, (2) services were previously authorized, (3) the provider is authorized, (4) the authorization period has not expired, and (5) continuation is specifically requested. These criteria are outlined in policy and member notices. No continuation cases occurred during the review period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
<p>31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE’s ABD, the MCE may, consistent with the state’s usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE’s contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(d)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Sample Inpatient Denial Letter Template • SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section IV.B, p. 14. Aligns with CFR §431 for cost recovery. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: If an appeal or SFH decision is adverse to the member, Magellan may recover the cost of services furnished during the appeal process, consistent with 42 CFR §431.230(b) and State policy. This is stated in Magellan’s policy and reviewed for compliance</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(b)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • SXIII. ABD Appeal Policy, Section I.N “Reversals and Payment,” p. 6-7. Requires MCE or State to pay for services delivered while appeal was pending, per State policy. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: If an appeal or SFH decision reverses the adverse benefit determination and services were delivered during the pending process, Magellan or the State must pay for the services. This policy provision ensures member access and appropriate reimbursement.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Reinstatement of Services		
<p>33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i)</p> <p>MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Tracking mechanisms HSAG will also use the results of the Appeals File Review <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> SXIII. CO.MCD.243.09 Adverse Benefit Determination Appeal Policy, Section III.C.E.i, p. 14. Requires MCE to authorize/provide services within 72 hours of receiving notice of reversal. 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: When an appeal or hearing decision results in a reversal of a service denial, Magellan authorizes or provides the services as quickly as the member's condition requires, and no later than 72 hours after receiving notice. This protocol supports timely access to care.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
Grievances, Appeals, and State Fair Hearings		
<p>34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook • Example of assistance to members on filing a grievance <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • CSoC Member Handbook p. 17 “If you need help filing a grievance...” • CSoC Grievance Acknowledgement Letter, pg 2, “Please let us know if you need help...” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Magellan offers reasonable assistance to members during the grievance and appeal process, including help with forms and access to auxiliary aids or interpreter services. These supports are explained in member materials and included in standard correspondence.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10.</p> <p style="text-align: right;">42 CFR §438.10 42 CFR §438.228 42 CFR §438.408(d)(1) 42 CFR §438.408(d)(2)(i) 42 CFR §457.1260(e)(1)</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 5.15.2; 5.15.3	Evidence as Submitted by the MCE: <ul style="list-style-type: none"> Templates of member letters Sample Denied Appeal Request Acknowledgement Letter Template Grievances: Language Requirements are tagged in each Member Grievance Sample Additional Documentation: <ul style="list-style-type: none"> XIII.35_Medicaid Enrollee Communication and Information Requirements - OP.MCD.338.10. Standard II.F, pp.5 (Please see page 9 for corporate policy life history and Evidence of 2024 Policy Review, XIII.35_Medicaid Communication Requirements_Evidence of 2024 Policy Review.) XIII.35_Medicaid Communication Requirements_Local Process (pp. 4) 	
MCE Description of Process: Grievance and appeal notices are written at a fifth-grade reading level and include required taglines and nondiscrimination statements. Templates are assessed using the Flesch-Kincaid tool to ensure compliance with 42 CFR §438.10.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Provider manual Provider contract 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1</p>	<p>42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g)</p> <ul style="list-style-type: none"> • Subcontractor agreement template. <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Subcontractor agreement template. Magellan does not have subcontractor agreement templates. <p>Additional Documentation:</p> <ul style="list-style-type: none"> • XIII.15 & 36 & 38_SXIII. CSoC Medicaid Enrollee Grievances Policy, Standard XI, pp.11 - 12; • SXIII. Medicaid ABD Appeal Policy, Standard SXIII. Medicaid ABD Appeal Policy, Standard SXIII. Medicaid ABD Appeal Policy, Standard VII, pp. 14 • XIII R9 Provider Handbook pg 38 (Grievances) & 48 (Appeals) • XIII.36_Magellan Network Provider Agreement, 1.23 (pp. 3) & 2.5 (pp. 4) 2.5 • Magellan Network Provider Agreement, 1.23 (pp. 3) & 2.5 (pp. 4) • Magellan does not have any subcontractor agreements for CSoC 	
<p>MCE Description of Process: Magellan does not have subcontractor agreement templates.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>37. The MCE includes as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5)</p> <p>MCO Contract: 2.15.3.1.6 PAHP Contract: 2.10.3.1.5 PIHP Contract: 11.4.2.4.2; 11.4.14.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Member materials, such as the member handbook and/or notice templates <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Sample Inpatient Denial Letter Template • Sample Approval Letter Template • Sample Denied Appeal Request Acknowledgement Letter Template • Grievances: CSoC Grievance Resolution Letter Template <p>Additional Documentation:</p> <ul style="list-style-type: none"> • SXIII.28 & 28 & 38_ Medicaid ABD Appeal Policy, Standard I.A.3, pp. 1 - 2 	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p>MCE Description of Process: Appeals and State Fair Hearings include the member and their representative, the legal representative of a deceased member’s estate, and Magellan as a party to the hearing. Roles are defined in policy and reflected in member correspondence.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan’s policies and procedures did not include as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. 		
<p>Required Actions: The MCE must submit evidence of how the MCE includes as parties to the appeal and SFH:</p> <ul style="list-style-type: none"> a. The member and his or her representative. b. The legal representative of a deceased member’s estate. c. For SFH, the MCE. 		



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
Recordkeeping Requirements		
<p>38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information:</p> <ol style="list-style-type: none"> a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. <p>PIHP:</p> <ol style="list-style-type: none"> a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members; f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals; 	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • 38.a-f: Grievances: Example of Grievance Record Keeping tagged in each Member Grievance Sample • 38.a-i (PIHP): Example of Grievance Record Keeping tagged in each Member Grievance Sample <hr/> <p>Additional Documentation:</p> <ul style="list-style-type: none"> • SXIII.28 & 28 & 38_Medicaid ABD Appeal Policy, Standard VII, pp.15 -16 • SXIII. Medicaid ABD Appeal Policy, Standard VI, pp. 14; • SXIII.15 & 36 & 38_CSoC Medicaid Enrollee Grievances Policy, VIII. Reporting and Record Keeping Standard IX, pp.11 -12 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and i. The number of State Fair Hearings and resolution during the reporting period. <div style="text-align: right; margin-right: 20px;"> 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) </div> MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 11.7.2		
MCE Description of Process: Magellan maintains accurate, accessible records of all grievances and appeals, including reasons, dates, outcomes, and resolution timeframes. Records include required PIHP fields and are available for review upon request by LDH or CMS.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	31	X	1	=	31
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	Total Score	=	31	

Total Score ÷ Total Applicable	=	84%
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Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Certification		
<p>1. Documentation or information the MCE submits to LDH is certified by the MCE’s Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.</p> <p>a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful.</p> <p>b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).</p> <p style="text-align: right;">42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o)</p> <p>MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification <hr/> <p>Evidence as Submitted by the MCE:</p> <p><i>Policy:</i></p> <ul style="list-style-type: none"> • LA CSoc Data Certification Reconciliation Process_2022 <p><i>Positions and Job Descriptions:</i></p> <ul style="list-style-type: none"> • Finance Director Job Description • VP, General Manager Job Description <p>Additional Documentation:</p> <ul style="list-style-type: none"> • Email of LDH submission and screenshot of data certification 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The process through which encounters are reconciled is fully described in the LA CSoc Data Certification Reconciliation Process attached.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
Compliance Program/Program Integrity Plan		
<p>2. The MCE develops a compliance program that includes:</p> <p>a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.</p> <p>b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.</p> <p>c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under the Contract.</p> <p>d. A system for training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees, for the Federal and State standards and requirements under the Contract.</p> <p>MCO and PAHP:</p> <p>a. <i>Fraud, waste, and abuse training shall include, but not be limited to:</i></p> <p style="margin-left: 20px;">i. <i>Annual training of all employees; and</i></p> <p style="margin-left: 20px;">ii. <i>New hire training within thirty (30) Calendar Days of beginning date of employment.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration <hr/> <p>Evidence as Submitted by the MCE:</p> <p><i>Policies and procedures</i></p> <p><i>PI & Compliance program referenced policy but not limited to.....</i></p> <ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Standard II, C, 1, & 2, Page 5) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>b. <i>The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:</i></p> <ul style="list-style-type: none"> i. <i>MCO/PAHP Code of Conduct Training;</i> ii. <i>Privacy and Security - Health Insurance Portability and Accountability Act;</i> iii. <i>Fraud, Waste, and Abuse identification and reporting procedures;</i> iv. <i>The False Claims Act and employee whistleblower protections;</i> v. <i>Procedures for Timely consistent exchange of information and collaboration with LDH;</i> vi. <i>Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and</i> vii. <i>Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.</i> <p>c. <i>Effective lines of communication between the compliance officer and the organization's employees.</i></p>	<ul style="list-style-type: none"> • * False Claims Laws and Whistleblower Protections; COMPRO.108.03 • COMPRO.109.xx - Excluded Individuals and Entities (Employees, Members of the Board of Directors, Volunteers, Contractors, Providers and Vendors); • *Corporate Compliance Hotline; COMPRO.110.01-2024 • * Corporate Compliance Structure with Business Divisions, and Corporate Departs- COMPRO.100.01-2024 • *Obligation to Report Potential Compliance Violations; COMPRO.102.01-2024 • * Corporate Compliance Committee COMPRO.111.01-2024 • *Network Practitioner Credentialing and Recredentialing CR.1102.25-policy <p><i>Program Integrity Compliance Plan</i></p> <ul style="list-style-type: none"> • Magellan's Medicaid Compliance Program and Medicaid Program Integrity Plan for both Medicaid and State Children's Health Insurance Program (SCHIP) contracts in compliance with 42 CFR 438.608 and 42 CFR 457.1285 are addressed in this policy, respectively. • Magellan PI Compliance Plan incorporates all OIG guidelines for Compliance programs. All requirements are outlined in the following Policy document: 	



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Standard XIV—Program Integrity								
Requirement	Supporting Documentation	Score						
<p>d. <i>Enforcement of standards through well-publicized disciplinary guidelines.</i></p> <p>e. <i>Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.</i></p> <p>PIHP:</p> <p>a. <i>Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;</i></p> <p>b. <i>A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;</i></p> <p>c. <i>Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if</i></p>	<ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Standard II, B, Page 4) <i>Program Integrity (PI) Annual Work Plan</i> • Magellan SIU Anti-Fraud Program (January 2024) <i>Compliance Officer job description</i> • Compliance Officer I_ job description <i>Organizational chart</i> • LA CSoC Organization Chart <i>Regulatory Compliance Committee charter</i> • CSOC Compliance Committee Charter <i>Compliance training plan.</i> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Standard II, G, Page 9,1-3) <i>Compliance training materials</i> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>2024 Code of Conduct</td></tr> <tr><td>2024 Privacy Essentials</td></tr> <tr><td>2024 Privacy Essentials for New Hires</td></tr> <tr><td>2024 FIRE</td></tr> <tr><td>2024 Conflicts of Interest</td></tr> <tr><td>2024 Government Contracts</td></tr> </table> <p><i>Training tracking mechanisms</i></p> <ul style="list-style-type: none"> • The CCO and the Human Resources Department are responsible for coordinating the training efforts for 	2024 Code of Conduct	2024 Privacy Essentials	2024 Privacy Essentials for New Hires	2024 FIRE	2024 Conflicts of Interest	2024 Government Contracts	
2024 Code of Conduct								
2024 Privacy Essentials								
2024 Privacy Essentials for New Hires								
2024 FIRE								
2024 Conflicts of Interest								
2024 Government Contracts								



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Requirement	Supporting Documentation	Score
<p><i>appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;</i></p> <p>d. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly; and</i></p> <p>e. <i>Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(1)</p> <p>MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7</p> <p>PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9</p> <p>PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11</p>	<p>the Compliance Program. Completion reports are provided when requested.</p> <ul style="list-style-type: none"> • Annual Training Completion report - 2024 • <i>Communication protocol for Compliance issues (e.g., hotline)</i> • Corporate Compliance Hotline-COMPRO,110.01-2024 <p><i>Additional independent reporting paths:</i></p> <ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Standard II, H, g & h, Page 11 & 12) <p><i>12 Code of Ethics</i></p> <ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Standard II, C,5, Page 5) • This Code of Conduct serves to familiarize individuals with the ethical standards that guide our business and customer relationships in the highly regulated environment. • 2023 Code of Conduct (External)_Feb2023_508 <p><i>Standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayment</i></p> <ul style="list-style-type: none"> • SIU:10-Louisiana CSOC Regulatory and Contractual Requirements 	



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Requirement	Supporting Documentation	Score
	<p><i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers</i></p> <ul style="list-style-type: none"> • SIU:25-SIU Site Visits 2024.03 <p><i>The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.</i></p> <ul style="list-style-type: none"> • False Claims Laws and Whistleblower Protections; COMPRO.108.03 <p>Additional Documentation:</p> <ul style="list-style-type: none"> • FU. Reporting plan violations 	
<p>MCE Description of Process: Magellan Health, its subsidiaries and affiliates, (Magellan) are dedicated to conducting business in an ethical and legal manner. Magellan’s Medicaid Program Integrity & Compliance Program describes our comprehensive plan for the prevention, detection and reporting of fraud, waste and abuse across various categories of health care related fraud (e.g., internal fraud, electronic data processing fraud, external fraud).</p> <p>Magellan has written policies, procedures and standards of conduct which mandate that every employee comply with all applicable Federal and state standards. Magellan aggressively pursues allegations of health care fraud, waste, and abuse. To provide comprehensive prevention, detection and awareness training. The Medicaid Program Integrity & Compliance Program helps employees understand and follow federal and state laws related to their jobs and demonstrates Magellan’s commitment to conducting business honestly and responsibly to the Medicaid and CHIP community and the community at large.</p> <p>The primary components of the Corporate Compliance Program include: 1. Written Policies and Procedures; 2. Designation of a Compliance Officer and a Compliance Committee; 3. Conducting Effective Training and Education; 4. Developing Effective Lines of Communication; 5. Enforcement through Publicized Disciplinary Guidelines and Policies Dealing with Ineligible Persons; 6. Auditing and Monitoring; 7. Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and 8. Whistleblower Protection and Non-Retaliation policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.</i></p> <p>MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <p><i>13.1.2.3.8. Provisions for prompt response to detected offenses and for development of corrective action initiatives relating to the contract.</i></p> <ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program <ul style="list-style-type: none"> – (Standard II, J & K, Page 13-18) – 42 CFR 438.608(a)(1)(vii) – (Addendum, A, Page 27) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The primary components of the Corporate Compliance Program include: 1. Written Policies and Procedures; 2. Designation of a Compliance Officer and a Compliance Committee; 3. Conducting Effective Training and Education; 4. Developing Effective Lines of Communication; 5. Enforcement through Publicized Disciplinary Guidelines and Policies Dealing with Ineligible Persons; 6. Auditing and Monitoring; 7. Responding to Detected Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities; and 8. Whistleblower Protection and Non-Retaliation policy.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>4. Additional compliance program requirements: MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO’s compliance program shall incorporate the following requirements:</i></p> <p style="margin-left: 40px;">i. <i>Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan <hr/> <p>Evidence as Submitted by the MCE:</p> <p><i>Provide and certify that the PIHP’s fraud, waste and abuse unit has access to records of providers.</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p><i>abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>ii. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.</i></p> <p>iii. <i>Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.</i></p> <p>iv. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.</i></p> <p>PAHP:</p> <p>a. <i>Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing</i></p>	<ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program – (Addendum Page 29 -13.5.18) <p><i>Develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP’s senior management.</i></p> <ul style="list-style-type: none"> • Magellan’s Legal department distribute policies to the local Policy coordinator/leadership when annual review is due. The policies are then distributed to the local leadership team for review and approval. This process is completed via email correspondence. • Sample email notification – Notification Published Corporate Policies Document (07-01-2024 – 07-09-2024) • Sample email notification – Local Policy review-approval msg <p><i>Description of effective training and education for the compliance officer, the organization’s employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it.</i></p> <ul style="list-style-type: none"> • 2024 FIRE training - Fraud, Waste, and Abuse identification and reporting procedures • Introduction: lesson 1 of 15 	



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Requirement	Supporting Documentation	Score
<p><i>patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>b. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.</i></p> <p>e. <i>Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.</i></p> <p>d. <i>Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.</i></p> <p>e. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP’s website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i></p>	<ul style="list-style-type: none"> – Course Details – In this training you will learn the following: <ul style="list-style-type: none"> • Recognizing FWA • FWA Laws and Regulations and the Associated Consequences • Preventing FWA • Reporting FWA <p><i>A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.</i></p> <ul style="list-style-type: none"> • Corporate Compliance Hotline-ComPRO.111.01-2024 	



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Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ul style="list-style-type: none"> a. <i>The PIHP’s fraud, waste and abuse policies and procedures shall provide and certify that the PIHP’s fraud, waste and abuse unit has access to records of providers.</i> <ul style="list-style-type: none"> i. <i>The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP’s senior management.</i> b. <i>Description of effective training and education for the compliance officer, the organization’s employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it</i> c. <i>A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.</i> <p>MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12</p>		
<p>MCE Description of Process: Magellan’s Legal department distribute policies to the local Policy coordinator/leadership when annual review is due. The policies are then distributed to the local leadership team for review and approval. This process is completed via email correspondence. On an annual basis, the corporate compliance policy lead, distributes policies to all applicable leadership, leadership disseminates to all department heads for review (sample email approval). Policy review is conducted in compliance committee meetings (or via email). Each department head would present their proposed changes in their applicable compliance committee. Changes are either approved by corporate or LA creates an addendum. Then, the revised policy is then uploaded.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
Required Actions: No action required.		
<p>5. Publicized email address: MCO and PAHP:</p> <p>a. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.</i></p> <p>b. <i>The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i></p> <p>MCO:</p> <p>a. <i>The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.</i></p> <p>MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program • FWA Laws and Regulations and the Associated Consequences • Reporting FWA <p>Additional Documentation:</p> <ul style="list-style-type: none"> • member.providers.public links to FWA reporting 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCE Description of Process: N/A		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
<p>6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH.</p> <p style="text-align: right;">42 CFR §438.608(a)(2)</p> <p>MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows fraud risk assessment • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials <hr/> <p>Evidence as Submitted by the MCE: <i>Policies and procedures, including timeline for prompt reporting of overpayments.</i></p> <ul style="list-style-type: none"> • <i>The 2023 version was in effect through 2024 and it was recently revised in 2025</i> • Administration of Claims Overpayment Recovery, OP.312.08-2025 policy • Administration of Claims Overpayment Recovery, OP.312.08-2023 <p><i>Special investigations unit (SIU) workflows</i></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> • Outcome Risk Assessment • SIU-10 – Louisiana CSOC Regulatory and Contractual Requirements <p><i>Identification mechanisms</i></p> <ul style="list-style-type: none"> • An overpayment is frequently, but not always, identified by one of the following eight core risks: Authorizations; Provider/facility rates; Benefits; Eligibility; Covered/mixed services; Coordination of benefits; Timely filing; and/or Fraud, waste, or abuse. Administration of Claims Overpayment Recovery, OP.312.08-2025 policy (Standard II, A, page 2) <p><i>Reporting mechanisms</i></p> <ul style="list-style-type: none"> • <i>SIU case recovery reporting - PI 145 Quarterly report.</i> • <i>Sample report – PI 145 Q22024 revised 8.2023 final</i> <p><i>Provider materials, such as the provider manual.</i></p> <ul style="list-style-type: none"> • <i>PI Ntwk Prov Medicaid Addendum</i> – (Pg. 7 section 4.5) • <i>PI LA CSOC Provider Handbook</i> – Page 58, bullet 2 & 3 <p><i>Staff training materials</i></p> <ul style="list-style-type: none"> – 2024 FIRE <p>Additional Documentation:</p> <ul style="list-style-type: none"> • https://www.magellanoflouisiana.com/for-providers/provider-toolkit/fraud-waste-abuse/ 	



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Requirement	Supporting Documentation	Score
<p>MCE Description of Process: Magellan's Cost Containment Department (CCD) responds to overpayment leads identified through various methods or departments, including but not limited to, Claims, Network, Legal, Internal Audit, Special Investigations Unit (SIU), and others.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
<p>7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.</p> <p>a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments.</p> <p>b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments.</p> <p>c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.</p> <p>MCO:</p> <p>a. <i>Report annually to LDH, in a form and format specified by LDH, on the MCO's recoveries of overpayments in accordance with 42 CFR §438.608.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.</i></p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials • Most recent report of recoveries of overpayments to State <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • PI 145 Q22024 revised 8.2023 • SIU:10-Louisiana CSOC Regulatory and Contractual Requirements (Page 4) • No provider refunds were identified through self-audit and/or self-disclosure during the timeframe reviewed. • Policy statement: SIU:10-Louisiana CSOC Regulatory and Contractual Requirements (Page 4) 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. <i>The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.</i></p> <p>PIHP:</p> <p>a. <i>The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.</i></p> <p>b. <i>The PIHP shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.</i></p> <p style="text-align: right;">42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3)</p> <p>MCO Contract: 2.20.2.2.15; 2.20.7.3 PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6</p>		
<p>MCE Description of Process: SIU will send overpayments for retraction to the Cost Containment Department (CCD) for handling. • If the provider is set up for retraction via future claims payments, the claims sent for recovery will be in a “Provider Withhold” status. • If Magellan fails to collect the identified overpayment within 180 days and the remaining amount to be collected is \$100 or greater, the identified claims will be sent to the collection agency contracted by Magellan and will be placed in a “Send for Collection” status. Referral of the recovery request to the collection agency must be approved by the General Manager, Finance Department and/or Legal Department. • If after 365 days of collection agency attempts have been exhausted, the identified claims will be placed in a status of “Collection Exhausted” status and Magellan staff will review when the collection activities have been exhausted. Magellan will report cases to PI in which collection efforts have been exhausted and indicate on required reporting.</p>		



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Requirement	Supporting Documentation	Score
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment.</p> <p style="text-align: right;">42 CFR §438.608(d)(2)</p> <p>MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Overpayment and monitoring mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • PI Ntwk Prov Medicaid Addendum, (Pg. 7 section 4.5) • LA CSOC Provider Handbook • Overpayment pg. 62 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The process on how the health plan reports for provider overpayments.		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element. The requirements were specified in the PI Ntwk Prov Medicaid Addendum but not in the LA CSOC Provider Handbook.</p> <p>Recommendations: HSAG recommends that the MCE align the LA CSOC Provider Handbook and PI Ntwk Prov Medicaid Addendum to include all requirements.</p>		
Required Actions: No action required.		



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Requirement	Supporting Documentation	Score
Notification of Member and Provider Changes		
<p>9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member’s circumstances that may affect the member’s eligibility including all of the following:</p> <p style="margin-left: 20px;">a. Changes in the member’s residence;</p> <p style="margin-left: 20px;">b. The death of a member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(a)(3)</p> <p>MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not have subcontractors. <p>Additional Documentation:</p> <ul style="list-style-type: none"> CSoC Intent to Discharge Workflow CSoC Discharge Workflow 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: Magellan does not have subcontractors.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
<p>10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider’s circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Staff training material <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Magellan does not have subcontractors. 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>PAHP:</p> <p>a. <i>The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network. The notification shall include:</i></p> <p style="margin-left: 20px;">i. <i>Information about how the provider network change will affect the delivery of covered services; and</i></p> <p style="margin-left: 20px;">ii. <i>The PAHP’s plan for maintaining the quality of enrollee care, if the provider network change is likely to affect the delivery of covered services.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:</i></p> <p style="margin-left: 20px;">i. <i>Information about how the provider network change will affect the delivery of covered services, and</i></p> <p style="margin-left: 20px;">ii. <i>The PIHP’s plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(a)(4)</p>	<p>Additional Documentation:</p> <ul style="list-style-type: none"> • At this time, our organization does not have a policy that specifically outlines the PIHP requirement to notify LDH within one (1) day of changes in a network provider’s circumstances that impact eligibility. However, we do address material changes to the network through our Annual Network Development Plan, where we include outcomes and instances of significant provider changes. • We recognize the importance of aligning with the PIHP-specific requirement and will develop or modify an existing policy to explicitly include the one (1) day notification standard. Going forward, we will also ensure that any outcomes or instances of provider changes impacting eligibility are incorporated into our Annual Network Development Plan to demonstrate compliance and accountability. 	



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Requirement	Supporting Documentation	Score
MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5		
MCE Description of Process: Magellan does not have subcontractors. The MCE did not submit a policy that demonstrated compliance with the requirements of this element.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan did not implement or maintain procedures related to this requirement.		
<p>Required Actions: The MCE must implement and maintain arrangements or procedures for notification to LDH when it receives information about a change in a network provider’s circumstances that may affect the network provider’s eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE. Additionally, the MCE must include the following process:</p> <p>The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:</p> <ol style="list-style-type: none"> i. Information about how the provider network change will affect the delivery of covered services, and ii. The PIHP’s plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services. 		
Verification of Services Provided		
11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Medicaid: Verification of Services Provided to Members COM.MCD.1924.02 	



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Requirement	Supporting Documentation	Score
<p>MCO:</p> <p>a. <i>On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice shall specify:</i></p> <p style="margin-left: 20px;">i. <i>Description of the service furnished;</i></p> <p style="margin-left: 20px;">ii. <i>The name of the provider furnishing the service;</i></p> <p style="margin-left: 20px;">iii. <i>The date on which the service was furnished;</i></p> <p style="margin-left: 20px;">iv. <i>The amount of the payment made for the service; and</i></p> <p style="margin-left: 20px;">v. <i>The method for notifying the Contractor of services not rendered.</i></p> <p>b. <i>The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis.</i></p> <p>c. <i>The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).</i></p> <p>d. <i>The Contractor shall track any responses received from Enrollees and resolve the responses according to its</i></p>	<ul style="list-style-type: none"> WAA_QI_PI Monitoring Training-Member Verification and Onsite Review-2 (Slides 1-6) PI147_Sampling-of-paid_claims_Report Q12025 	



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<p><i>established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i></p> <p>e. <i>Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the MCO’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.</i></p> <p>PAHP:</p> <p>a. <i>On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:</i></p> <ul style="list-style-type: none"> i. <i>Description of the service furnished;</i> ii. <i>The name of the provider furnishing the service;</i> iii. <i>The date on which the service was furnished; and</i> iv. <i>The amount of the payment made for the service.</i> 		



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<p>b. <i>Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis.</i></p> <p>c. <i>The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and</i></p> <p>d. <i>Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.</i></p> <p>e. <i>Within three (3) business days, results indicating that paid services may not have been received shall be referred to the PAHP’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.</i></p> <p>PIHP:</p> <p>a. <i>On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the</i></p>		



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<p><i>members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:</i></p> <ul style="list-style-type: none"> <i>i. The service furnished;</i> <i>ii. The name of the provider furnishing the service;</i> <i>iii. The date on which the service was furnished; and</i> <i>iv. The amount of the payment made for the service.</i> <p><i>b. The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.</i></p> <p><i>c. Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.</i></p> <p><i>d. The Contractor shall over sample particular provider groups upon request by LDH.</i></p> <p><i>e. The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i></p> <p><i>f. Within five (5) business days, results indicating that paid services may not have been received shall be</i></p>		



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<p><i>referred to the Contractor’s fraud and abuse department for review and to LDH’s designated Program Integrity contact.</i></p> <p><i>g. The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(5)</p> <p>MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4</p>		
<p>MCE Description of Process: On a monthly basis, Magellan reporting Unit selects claims for member verification. The sample list is sent to the PI Compliance officer for review and distribution. The CLO emails the surveys to each of the WAAs in all 9 region for face to face or telephonic completion of the survey by the member and the WAA facilitators. The completed surveys are sent back to the CLO for review and processing. The PI 147 report is generated quarterly. All negative response are verified and process after information is verified by the CLO. WAAs training document attached.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Whistleblower Protection		
<p>12. In the case of MCEs that make or receive annual payments under the contract of at least \$5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures,</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.</p> <p>MCO:</p> <p>a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO’s policies and procedures for detecting and preventing fraud, waste and abuse.</p> <p style="text-align: right;">42 CFR §438.608(a)(6)</p> <p>MCO Contract: 6.18.1; 6.18.3 PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7 PIHP Contract: 13.1.1.2.; 13.1.2.8</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> COMPRO.MCD.105.01. CSoc.A.01 Medicaid Program Integrity and Compliance Program) II,pg4, B,8) (II.pg.5.C,2) False Claims Laws and Whistleblower Protections; COMPRO.108.03 2024 FIRE training Provider Handbook <p>Additional Documentation:</p> <ul style="list-style-type: none"> PI147_Sampling-of-Paid_Claims_Report Q12025 	
<p>MCE Description of Process: The process on how the health plan upholds and maintains for payments received and made by a certain amount that includes the notifications/policies and procedures of the False Claims Act and Federal and State laws regarding provisions for coverage of services for payments to all involved for the service of business agreed upon between the health plan and state partner.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		
Fraud, Waste, and Abuse		
<p>13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures:</p> <p>a. That are designed to detect and prevent fraud, waste, and abuse.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Fraud, waste, and abuse plan SIU workflow Reporting mechanisms Staff training materials 	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH’s program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU).</p> <p>PAHP:</p> <p>a. <i>The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (MFCU) and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A standardized referral process should be developed to expedite information for appropriate disposition.</i></p> <p style="text-align: right;">42 CFR §438.608(a) 42 CFR §438.608(a)(7)</p> <p>MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4</p>	<p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> 10-Louisiana CSOC Regulatory and Contractual Requirements. Pg. 6 Outcome Risk Assessment COMPRO.MCD.105.01.CSoC.A.01 Medicaid_Program Integrity and Compliance Program (pg. 14,2,a & b) 	
<p>MCE Description of Process: The process on how the health plan upholds and maintains for payments received and made by a certain amount that includes the notifications/policies and procedures of Fraud Waste and Abuse regarding provisions for coverage of services for payments to all involved for the service of business agreed upon between the health plan and state partner.</p>		
<p>HSAG Findings: HSAG has determined that the MCE met the requirements for this element.</p>		
<p>Required Actions: No action required.</p>		



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Suspension of Payments		
<p>14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.</p> <p style="text-align: right;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> • Policies and procedures • Payment suspension workflow • Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> • Process description below <hr/> <p>Additional Documentation:</p> <ul style="list-style-type: none"> • SIU Standard Operating Procedure 15 - Credible Allegation of Fraud (CAF) Payment Holds_2.10.2025 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: Process regarding the system work triggers the denial of claims payment when there is a Credible Allegation of Fraud.</p> <p>Adding a CAF Nuance</p> <ol style="list-style-type: none"> 1. Notification of CAF is received from the State, via Magellan Network Director, QI, or the Compliance Department. 2. Confirmation is made that the individual or entity suspended is a positive match to provider in Magellan’s network in the Integrated Provider Database (“IPD”). 3. A nuance code is placed in screen 5 of IPD to deny claims payment. <ol style="list-style-type: none"> 1. Add “2R” nuance if Magellan can communicate reason for denial to the provider in Screen 5 of IPD. <p>or</p> <ol style="list-style-type: none"> 2. Add “2S” nuance if Magellan cannot communicate reason for denial to the provider in Screen 5 of IPD. 3. Comment placed in Screen 13 of IPD. 4. The original internal requestor is notified of completion. <p>Removing a CAF Nuance</p> <ol style="list-style-type: none"> 1. Notification to lift or remove the CAF is received from the State, via Magellan Network Director, QI, or the Compliance Department to “lift” the hold. 		



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2. The nuance code triggering the hold is end dated or voided, using the effective date provided by the Director QI/Compliance or that indicated in the notification letter. 3. The original internal requestor is notified of completion.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c). <div style="text-align: right; margin-right: 100px;"> 42 CFR §438.608(a)(8) 42 CFR §455.23 </div> MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19	HSAG Required Evidence: <ul style="list-style-type: none"> Policies and procedures Payment suspension workflow, including applicable timeframes Notice of payment suspension letter template Staff training materials HSAG will also use findings from the provider payment suspensions tracking system demonstration Evidence as Submitted by the MCE: <ul style="list-style-type: none"> PI LA CSoc Provider Handbook Additional Documentation: <ul style="list-style-type: none"> SIU Standard Operating Procedure 15 - Credible Allegation of Fraud (CAF) Payment Holds_2.10.2025 XIVR15 TEMPLATE_Individual Pvdr Term for Cause admin rvw_v2018 v2 TEMPLATE_Initial Denial Letter with Admin Rvw_v2018 v2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The process on how the health plan upholds, maintains and notifies for suspension of payments for providers.		



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HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Provider Screening and Enrollment Requirements		
<p>16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E</p> <p>MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Medicaid enrollment verification workflow Two examples of documented Medicaid enrollment verifications Staff training materials <hr/> <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Provider Enrollment Workflow We do not have examples because we did not keep any screenshots during 2024. <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provider Handbook Proposed Updates for SIV R16 and R17 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
MCE Description of Process: The process on how the health plan upholds and maintains in the agreed upon enrollment with the state partner for providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Recommendations: HSAG recommends that the MCE develop a formal policy to codify the requirements of this element in accordance with the submitted workflow.		
Required Actions: No action required.		



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<p>17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days.</p> <p style="margin-left: 20px;">a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.602(b)(2)</p> <p>MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures Medicaid enrollment timeliness tracking mechanisms Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> Provider Enrollment Workflow <p>Additional Documentation:</p> <ul style="list-style-type: none"> Provider Handbook Proposed Updates for SIV R16 and R17 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>MCE Description of Process: The process on how the health plan upholds and maintains in the agreed upon enrollment with the state partner for providers.</p>		
<p>HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Magellan did not submit a policy or describe a process to demonstrate compliance with the execution and termination of provider agreements in accordance with the time frames specified in this requirement.</p>		
<p>Required Actions: The MCE must develop a process to execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 calendar days. Additionally, the MCE must terminate a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120-day period without enrollment of the provider, and notify affected members.</p>		
Disclosures and Prohibited Affiliations		
<p>18. The MCE, and any subcontractors:</p> <p style="margin-left: 20px;">a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610.</p> <p style="margin-left: 20px;">b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.</p>	<p>HSAG Required Evidence:</p> <ul style="list-style-type: none"> Policies and procedures that apply to provider/contracted entities and the MCE Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract.</p> <p>MCO:</p> <p>a. <i>Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars (\$25,000), even if there is no suspicion of fraudulent activity.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610</p> <p>MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13</p>	<ul style="list-style-type: none"> Disclosure of ownership and control notice template (required for completion by contracted entities) Confirmation MCE disclosures were provided to LDH upon contract execution Staff training materials <p>Evidence as Submitted by the MCE:</p> <ul style="list-style-type: none"> PI Ntwk. Prov Medicaid Addendum PI LA CSOC Provider Handbook <ul style="list-style-type: none"> – (Pg. 11, Updated Practice information, Note. section 4.5) – Pg. 55, The quality Partnership, #4, a.) – Pg. 57, Disclosure requirement Medicaid Disclosure Form (MDF) 	
MCE Description of Process: The process on how the health plan upholds and maintains in agreements and affiliation with providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	16	X	1	=	16
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	Total Score	=	16	

Total Score ÷ Total Applicable	=	89%
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Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	Evidence as Submitted by the MCE		Score
1. <div style="text-align: right; font-size: small;"> <Insert federal CFR citation> Contract: <Insert Citation(s)> </div>	MCE Document Submission: <ul style="list-style-type: none"> 		<input type="checkbox"/> Met <input type="checkbox"/> Not Met
HSAG Findings:			
Required Actions:			
Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
CAP Approval Status:			
Submission:			