UnitedHealthcare of Louisiana

2016 Compliance Audit

Review Period: September 2015 – August 2016

Issued April 2017

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

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Section 1: Introduction and Audit Overview

INTRODUCTION

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct Annual Compliance Audits every three years, followed by partial audits in the intervening years. The 2016 Annual Compliance Audit was a full audit of MCO compliance with contractual requirements during the period of September 1, 2015 through August 31, 2016.

This report presents IPRO's findings of the 2016 Annual Compliance Audit for UnitedHealthcare of Louisiana (UnitedHealthcare).

AUDIT OVERVIEW

The purpose of the audit was to assess UnitedHealthcare's compliance with federal and state regulations regarding access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The audit included a comprehensive evaluation of UnitedHealthcare's policies, procedures, files and other materials corresponding to the following nine (9) domains:

1. Core Benefits and Services
2. Provider Network
3. Utilization Management
4. Eligibility, Enrollment and Disenrollment
5. Marketing/Member Education
6. Member Grievances and Appeals
7. Quality Management
8. Reporting
9. Fraud, Waste and Abuse

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

Specifically, file review consisted of the following seven (7) areas:

1. Appeals
2. Behavioral Health Care Management
3. Case Management
4. Informal Reconsiderations
5. Member Grievances
6. Provider Credentialing/Recredentialing
7. Utilization Management Denials

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Behavioral Health Care management	10
Case Management	10
Informal Reconsiderations	5
Member Grievances	10
Provider Credentialing	5
Provider Recredentialing	5
Utilization Management Denials	10

The period of review was September 1, 2015 through August 31, 2016. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," and "compliance not met" were used for each element under review. The definition of each of the review determinations is presented in **Table 2**.

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The MCO has met or exceeded the standard.
Substantial	The MCO has met most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO has met some of the requirements of the standard, but has significant deficiencies that require corrective action.
Not Met	The MCO has not met the standard.

The 2016 Annual Compliance Audit consisted of three phases: 1) pre-onsite documentation review, 2) onsite visit and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared nine (9) review tools to reflect the areas for audit. These nine tools were submitted to the LDH for approval at the outset of the audit process in October 2016. The tools included the review elements drawn from the state and federal regulations. Upon reviewing the tools, LDH recommended elements to be added to the review tools to ensure completeness. Based upon the LDH's suggestions, the tools were revised, incorporating the elements added by LDH, and issued as final. These final tools were submitted to the MCO in October 2016 in advance of the onsite audit. All Medicaid MCOs in Louisiana were audited using the same review tools.

Once LDH approved the methodology, IPRO sent UnitedHealthcare a packet that included the review tools along with a request for documentation and a guide to help MCO staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure FTP site.

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

Prior to the onsite visit, the MCO submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The MCO was given a period of approximately four weeks to submit documentation to IPRO. To further assist MCO staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs undergoing the audit, with LDH staff in attendance, approximately one week after the request packet was sent to the MCOs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline and answered any questions posed by MCO staff.

After the MCO submitted the required documentation, a team of three (3) experienced IPRO auditors was convened to review the MCO's policies, procedures and materials and assess their concordance with the state's contract

requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the onsite review discussion.

Onsite Visit

The onsite component of the audit was comprised of a two (2) day onsite visit, which included a review of elements in each of the nine (9) review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited UnitedHealthcare on December 6–7, 2016 to conduct the interview and file review components of the audit. Staff interviews during the onsite visit were used to further explore the written documentation and for the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy was conducted in accordance to state standards.

Post-onsite Report Preparation

Following the onsite audit, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that the standard was met or a rationale for why the standard was not met and what evidence was lacking. For each element not fully compliant, IPRO provided a recommendation for the MCO to consider in order to attain full compliance.

Each draft report underwent a second level of review by IPRO staff not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval the draft reports were sent to the MCO with a request to furnish any additional documentation for all elements that were determined to be less than fully compliant. The MCO was given approximately two weeks to respond to the issues noted on the draft reports.

After receiving the MCO's response and any additional documentation, IPRO re-reviewed each element for which the MCO provided a response and missing documentation. As a result, several elements' review scores were either raised or converted to "Full Compliance" based on the additional documentation submitted and the reports were issued as final.

Section 2: MCO Summary of Findings

SUMMARY OF FINDINGS

Table 3 below provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Not Met	N/A	% Full
Core Benefits and Services	123	119	0	3	0	1	98%
Provider Network	163	160	2	1	0	0	98%
Utilization Management	92	90	2	0	0	0	98%
Eligibility, Enrollment and Disenrollment	13	13	0	0	0	0	100%
Marketing/Member Education	77	75	2	0	0	0	97%
Member Grievances and Appeals	62	55	6	1	0	0	89%
Quality Management	86	83	1	1	0	1	98%
Reporting	1	1	0	0	0	0	100%
Fraud Waste and Abuse	105	102	3	0	0	0	97%
TOTAL	**722**	**698**	**16**	**6**	**0**	**2**	**97%**

As displayed in the above, 722 elements were reviewed; 16 were determined to be "substantially met" and 6 were "minimally met." Two elements were not applicable and none were "not met." The remaining 698 were "fully met." The overall compliance score was 97%.

It is IPRO's and the LDH's expectation that UnitedHealthcare submit a corrective action plan for each of the 22 elements determined to be less than fully compliant along with a timeframe for completion. It should be noted that UnitedHealthcare has implemented a corrective action for many of the areas identified for improvement in the report but the corrections were made after the audit was completed and were not applicable to the audit's review period. One of the 22 elements rated less than fully compliant relate to network adequacy and the MCO's ability to contract with providers in several specialty and sub-specialty areas, a problem for all Medicaid MCOs in Louisiana that is not unique to UnitedHealthcare**.**

IPRO extracted from each of the nine detailed reports each element that the MCO was found to be less than fully compliant into a summary report to facilitate corrective action. This summary report includes each element reviewed, the final review determination, the MCO's initial response and suggestions to achieve full compliance.

Table 4: Deficient Audit Elements for UnitedHealthcare

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
Core Benefits and Services					
6.27.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	CS PCCM 2.0 Transition of Care	Minimal	CS PCCM 2.0 Transition of Care does not reference this specific element (5 or more ED visits in most recent 12 month period for chief complaint of pain, etc Onsite staff discussed their ED visit trigger process, whereby members with 2 ED visits over a 30 day period are flagged for care management review, but nowhere are ED visits with a chief complaint of pain specifically referenced. It is recommended that the plan's ED trigger process be modified to add ED visits for pain as a specific criterion for review.	UHC: Agree with the recommendation.
6.38.3.1	The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are	PCCM Program Description CS PCCM 2.0 Chronic Illness Program Management	Minimal	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG. IPRO reviewed a random sample of twenty (20) care management files, 10 of which were members in behavioral health care management. Review results indicated the following: 9 of the 20 files did not have documentation that an individual needs assessment or a diagnostic assessment was conducted, 7 of the 20 files did not have evidence of a care plan, 7 of 20 files lacked evidence of short and long term treatment objectives, 8 of 20 files lacked evidence of a plan of care for members with Special Health Care Needs. The files not meeting compliance in these areas were **non** behavioral health files. The majority of the members in this group had diagnoses which would indicate some level of care management assessment (e.g. diabetes, renal failure).	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	discharged from a 24-hour facility.			It is recommended that Care Management staff conduct a focused review of the Care Management system, to clearly identify those members in need of appropriate assessments and develop care plans where appropriate.	
6.39.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	PCCM Program Description Complex Case Management Program	Minimal	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG. IPRO reviewed a random sample of twenty (20) care management files, 10 of which were members in behavioral health care management. Review results indicated the following: 9 of the 20 files did not have documentation that an individual needs assessment and diagnostic assessment was conducted, 7 of the 20 files did not have evidence of a care plan, 7 of 20 files lacked evidence of short and long term treatment objectives, 8 of 20 files lacked evidence of a plan of care for members with Special Health Care Needs. The files not meeting compliance in these areas were **non** behavioral health files. The majority of the members in this group had diagnoses which would indicate some level of care management assessment (e.g. diabetes, renal failure). It is recommended that Care Management staff conduct a focused review of the Care Management system, to clearly identify those members in need of appropriate assessments and develop care plans where appropriate.	UHC: Agree with the recommendation.
Provider Network					
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Minimal	Specific components of this element (developing a written plan within 30 days and notifying DHH in writing) were not explicitly stated in the Network Provider Development Mgt Plan, nor in specific provider contracts.	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing			Recommendation: Revise the Network Provider Development Plan to explicitly include language regarding the development of a written plan within 30 days and notification to LDH. An amendment was subsequently drafted to the Network Provider Development Plan, which explicitly states this element, and was sent to IPRO as a follow up.	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	LA_Acute_Care Provider_Manual	Substantial	EPSDT/Prevention Physical Examinations discusses the need for PCPs to conduct a behavioral health screening, but this only addresses children and young adults, 21 yrs. Other age groups not addressed. The Provider Manual makes reference to identifying behavior health issues as a PCP responsibility, but does not specifically reference screening for various disorders (e.g. depression, anxiety, trauma/ACEs). Recommendation: Staff should amend Provider Manual to include these specific behavioral screenings, and also insure that these activities are tracked on Medical Record Audit Tools, for monitoring purposes going forward. The plan is in process of revising their Provider Manual accordingly.	UHC: Agree with the recommendation.
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3	Substantial	Geo Access Reports, Accessibility analysis reports, and Network adequacy Reports all clearly document provider geographic availability, including any action plans /corrective measures for identifying gaps. A number of gaps exist across various providers, of note are: • FQHCs • Nuclear Medicine • OB/GYNs • Occupational Therapists • Various pediatric specialties	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation		IPRO's review of the plan's Provider Gap Narratives provides a comprehensive picture of the gaps that exist across providers, including the above provider types. Efforts are clearly being made to contract with providers wherever possible.	
Utilization Management					
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Substantial	Requirement addressed by: The (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits: Table 3A. Standard Pre-Service Coverage Determinations – Outpatient (Authorizations) (p. 38) – 14 days Table 3B. Standard Pre-Service Non-Coverage Determinations (Denials) (p. 39) – 14 days <u>Recommendation</u> The physical health P/P notes 80% of standard determinations should be made within 2 business days of receipt of information. The behavioral health P/P notes only a 14 calendar day requirement from receipt of request, and should include TAT goals. At interview, the MCO notes the Medical Management P/P prevails, and the required language will be added to the Behavioral Health P/P.	UHC: Agree with the recommendation.
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as	UHC CP LA Medicaid Utilization Management Policy-final 062416	Substantial	Requirement addressed by the (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 6) policy and the UHC CP LA Medicaid Utilization Management Policy.	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	UCSMM 06 16 Initial Review Timeframes		It is also addressed in the Utilization Management of Behavioral Health Benefits policy:– Tables 1A through 4B as cited previously in this review (p. 33-40). During file review, In all instances except one, the Issuance of Notice of Action is included within the relevant time period to render the determination. Regarding Table 1C Post-Stabilization Authorizations and Actions, the Delivery of Verbal Notice is made within one hour, and the Issuance of Written Notice is made within one day.	
Marketing/Member Education					
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Substantial	Requirement substantially addressed by: UHC Member Education PP - Required Materials (p. 10) Member Handbook for Physical Health Services (p. 12, 49) Member Handbook for Mental Health and Substance Use Treatment Services (p. 13, 32) UHC Member Education PP - Required Materials (p. 13) notes the member is informed of interpretation services available *at no cost* during the Welcome Call. UCSMM 06 11 Accessibility and Initial Response P/P (p. 1) notes interpretation services available at *toll-free* numbers. <u>Recommendation</u> The Member Handbook should also state interpretation services are available at no cost to the member.	UHC: Agree with the recommendation.
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This	Member Handbook for Physical Health Services	Substantial	Requirement addressed as cited in 12.9.8. Spanish noted in the: Member Handbook for Physical Health Services	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	instruction shall be included in all versions of the handbook in English and Spanish ;			(p. 12) and the Member Handbook for MH and SU Treatment Services (p. 13) <u>Recommendation</u> Member handbooks should state interpretation services are available at no cost to the member.	
Member Grievances and Appeals					
13.2.3	**Time Limits for Filing** The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	LA_Handbook_EN UCSMM 07 11 Appeal Review Timeframes	Substantial	On-site: Evidence in support of this requirement was found on Page 56 of the Member Handbook; however, this requirement is not addressed in the Grievance POL 2015-01. In the Appeals Process Policy UHL_12.0, this is addressed with regard to the timeframe between an appeal determination and State Fair Hearing request, but does not with regard to 30 days from MCO action or grievance event to grievance or appeal filing. <u>Recommendation</u>: The plan should address the requirement to allow the member 30 days from MCO action or grievance event to grievance or appeal filing in a single revised policy document that addresses both appeals and grievances, as there are inconsistencies (both overlaps and gaps) between what is noted as the appeals policy and what is noted as the grievance policy and, consequently, the policy is not clearly communicated. Or the plan may elect to reconcile theses inconsistencies by retaining separate appeals and grievance policies. <u>Global Recommendation</u>: It is also a general recommendation that either a single Grievance and Appeals policy or separate Grievance and Appeals policies be developed in order to comprehensively address and clearly convey the	<u>Plan's response post-onsite</u>: The plan will revise its Grievance System policy to reflect the current Louisiana contractual requirement of 30 calendar days. The plan is also revising its policy to clarify references to appeal process and for grievances UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				contract requirements (including those listed in UCSMM 07 12 Appeal Process and Record Documentation.pdf) without duplication. Policies should be named appropriately so that it is clear whether it they apply to appeals, only, grievance, only, or both.	
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	LA Inquiries Grievances and State Fair Hearings LA Grievance Coordinator (SFH) - SOP (update August 2016)	Substantial	POL 2015-01 grievance Process addresses this requirement generally by stating that the plan is required to submit information regarding appeal and grievance activity as directed by DHH, but does not specifically address **prompt forwarding of adverse decisions** to DHH upon DHH or **member** request. Recommendation: The plan should address this requirement in a policy that addresses both appeals and grievances.	Plan post-onsite response: The plan will update the policy to make clearer that it shall promptly forward adverse decisions to LDH upon request by the LDH or member. UHC: Agree with the recommendation.
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) 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 monthly grievance log;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) Acknowledgement Letter template UCSMM 07 11 Appeal Review Timeframes	Substantial	Grievance POL 2015-01, Page 3, addresses that acknowledgement letters "will be sent upon receipt of the appeal," but does not address the 5 day timeframe nor address grievances. On page 4, POL 2015-01 addresses sending written acknowledgement of an appeal within 3 working days of receipt if appeal is submitted in writing, but again, does not address acknowledgement of grievances. POL 2015-01 generally addresses the requirement for logging appeals and grievances, but does not specifically address the requirement to report in the monthly grievance log those grievances resolved same day. File Review Findings: 3 of 15 files were not compliant with this requirement. Recommendation: The plan should revise the relevant policies and procedures to address these requirements.	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 13 Appeal Notices	Minimal	The requirement that individuals deciding appeals not be involved in previous reviews/decisions was met on Page 3 of Grievance POL 2015-01; the requirement that appeals regarding medical necessity or clinical issues be reviewed/decided by a health care professional with appropriate clinical expertise was met on Pages 4-5 of POL 2015-01; however, although this document is described as pertaining to Member Grievances, evidence was not found to support these requirements with respect to grievances. File Review Findings: None of the 5 applicable files were compliant with this requirement. Recommendation: The plan should address this requirement for both appeals and grievances in the appropriate policy(s).	Plan's post-onsite response: The plan will update its Grievance System policy to clarify. UHC: Agree with the recommendation.
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Chief Medical Officer job description Dr. Ann Kay Logarbo, Medical Director/Chief Medical Officer	Substantial	The Chief Medical Officer job description was cited by the plan as evidence in support of this requirement; however, this document did not contain language regarding appeals and grievances. Post onsite, the plan provided POL 2015-01 which did include language that met this requirement. File Review Findings: 1 of 5 applicable cases met this requirement.	UHC: Agree with the recommendation.
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 13 Appeal Notices	Substantial	Evidence of most of these requirements was found on Page 7 of Grievance POL 2015-01; however, the date of the resolution was not included in the list of elements in the notice of appeal resolution letter. Plan's response: The plan will update its Grievance System policy (POL 2015-1). However, the appeal determination letter template does include verbiage to enter the date of the resolution. File Review Findings:	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.			4 of 15 files were not compliant with the requirement to include the results of the resolution process. 6 of the 15 files were not written in an easily understandable manner.	
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) Urgent Downgrade Ack Ltr template UCSMM 07 11 Appeal Review Timeframes	Substantial	Evidence of the requirement to transfer the appeal to the standard resolution time frame was found on Page 5 of Grievance POL 2015-01. However, the Urgent Downgrade Ack Ltr template address the member's right to file a grievance or that this does not constitute an Action. Plan Response post-onsite: The Plan will update the policy to clarify that the denial of a member's request for expedited resolution does not constitute n Action by the Plan. The plan also will update its Urgent Downgrade Acknowledgement letter template to inform the member of the right to file a grievance of the denial of the request for expedited resolution, and that the denial does not constitute an Action by the plan.	UHC: Agree with the recommendation.
Quality Management					
14.1.8.	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QIPD 2016 C_S _LA_FINAL_EQRO	Minimal	Page 9 of the QIPD 2016 document addresses this requirement specifically for members with complex health, i.e., high-cost, complex, at risk individuals including those with physical and developmental disabilities as well as those with chronic health needs. On-site, the plan discussed how the plan addresses needs of the following	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				subpopulations with special health care needs: Pediatric Day Health Care receive specialized CM services; Members needing private duty health care services; and members on ventilation assisted care who receive home visits. <u>Case Management File Review Findings</u> 3 of 10 case management files did not have a diagnosis documented. 9 of 10 case management files did not have documentation that an individual needs assessment and diagnostic assessment was conducted. 7 of 10 case management files did not have evidence of a care plan. 5 of 9 applicable files lacked evidence of involvement of member/family in treatment care planning, and 6 of 9 applicable files lacked evidence of revision of treatment plan as needed. 7 of 10 files lacked evidence of short and long term treatment objectives. 8 of 10 files lacked evidence of a plan of care for members with Special Health Care Needs. 5 of 10 files lacked evidence of coordination of activities with the Chronic Care Management Program. 9 of 10 files did include evidence of care coordination and monitoring of outcomes.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant	LA - Member Advisory Plan Charter 12-19-2014	Substantial	There is evidence to support this requirement in the LA Member Advisory Plan Charter and in the cover sheet for the Member Advisory Council meeting minutes. Post on-site, the plan provided quarterly MAC meeting minutes; however, there was no evidence that a family member/caregiver of a child with special health care needs attended, and per the quarterly meeting minutes provided, members comprised between 1/5 and 1/6 of the committee participants.	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.				
Fraud, Waste and Abuse					
15.1.5	MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2) <u>Recommendation</u> The Plan also cites contract references, but the language in regulation 15.1.5 was not found. The Plan grants access to contact and conduct private interviews with MCO clients, employees and contractors. Consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and any other process is not addressed. The MCO agrees such language could be added at the upcoming annual review.	UHC: Agree with the recommendation.
15.3.4	The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8) <u>Recommendation</u> Submitted evidence of compliance on page 8 references 1128A (a) of the Social Security Act; reference to 42 CFR 1003.102 (a) (2) is not found at this location. The MCO should include in its policy contract requirement language; specifically, regarding Medicaid payment to another provider who is not excluded (pharmacy).	UHC: Agree with the recommendation.

Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).				
15.3.4.1	An individual who is an affiliate of a person described above include: • A director, officer, or partner of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8, labeled 15.3.4.1). The Plan addresses only MCO employee, network providers, contractor or contractor employee. Though section 1128A of the Social Security Act is cited; section (a)(4)(A) generally addresses ownership. <u>Recommendation</u> Language pertaining to directors, officers, partners, 5% or more ownership, and provision of services material to the MCO's obligations should be considered for inclusion in the Plan.	UHC: Agree with the recommendation.

Section 3: MCO Final Audit Tools

Nine detailed final audit tool reports that correspond to each domain that was audited. These reports include IPRO's review determination for each element that was audited.

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**				
6.4.5 6.4.5.1	**Permanent Supportive Housing** DHH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Bayou Health members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388. Overall management of the PSH program is centralized within DHH and final approval for members to participate in PSH is made by the DHH PSH program staff. For the Louisiana PSH program, the MCO shall:				
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	PSH Workflow	Full	PSH Workflow Pg 1 satisfies this element	
6.4.5.1.2	Assist members in completing the PSH program application;	PSH Workflow	Full	C & S Care Management General Process, Section 15: Liaison Program	
6.4.5.1.3	Within one (1) working day of request by designated DHH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	PSH Workflow	Full	PSH Workflow satisfies this requirement	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the DHH PSH program manager; and	UHC Narrative Template 2016 PSH Outreach Standard	N/A	Template not yet in use—still in approval process	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1				

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	the MCO shall:				
6.4.5.2.1	Identify a PSH program liaison, to be approved by DHH, to work with DHH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	LA BH Org Chart	Full	LA BH Org Chart pg 1 satisfies this requirement	
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting. The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards.	LA_Acute_Care_Manual_PCA-1-003116 LA_Behavioral_Health_Resources	Full	Satisfied via Acute Care Manual and LA Behavioral Health Resources docs	
6.4.9.1	The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	ADHD PIP LA Quality_UHC101316 Example 1 LA_Acute_Care_Manual_PCA-1-003116 LA_Behavioral_Health_Resources	Full	Satisfied via ADHD PIP Quality, Acute Care Manual, Behavioral Health Resources	
6.4.9.2	The MCO shall work to increase provider utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	LA_Acute_Care_Manual_PCA-1-003116 LA_Behavioral_Health_Resources	Full	Satisfied via Acute Care Manual, Behavioral Health Tool	
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral	Triage, Referral and Specialized Clinical Decisions We offer Crisis Intervention and Crisis Stabilization	Full	336 Behavioral Health Providers Report Summary Quarterly , 24/7 behavioral health crisis line satisfies the requirement	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	services as "in-lieu" of services. These are not actual covered benefits: 336_Behavioral_Health_Providers_by_Level_of_Care_Summary_quarterly_UHC_Q2_071816 We also offer a 24/7 behavioral health crisis line: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana/lookup-tools.html#behavoral-health			
6.8	**Emergency Medical Services and Post Stabilization Services**				
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Utilization Management of Behavioral Health Benefits UCSMM 04 11 Consumer Safety	Full	Util Mgt of Behavioral Health and UCSMM 04 11 Consumer Safety support this requirement	
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	LA_Handbook_EN LA_Mental_Health_Substance_Handbook	Full	LA Handbook EN and LA Mental Health Substance Handbook support this requirement	
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	LA_Handbook_EN LA_Mental_Health_Substance_Handbook	Full	LA Handbook EN and LA Mental Health Substance Handbook support this requirement	
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	LA_Handbook_EN LA_Mental_Health_Substance_Handbook	Full	LA Mental Health Substance Handbook support this requirement	
6.8.1.5	The attending emergency physician, Licensed	Utilization Management of	Full	Util Mgt of Behavioral Health	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	Behavioral Health Benefits LA_Acute_Care_Manual_PCA-1-003116		Section P supports this requirement	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	Utilization Management of Behavioral Health Benefits	Full	Util Mgt of Behavioral Health Section P supports this requirement	
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	LA ER Diversion_SR29 Progress Measures Specifications LA ER Scripting	Full	LA ER Diversion_SR29 Progress Measures Specifications pg 1-2 LA ER Scripting pg 1-6	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	CST9696_NT16_LA_ERdiversion_brochure_PR LA_Acute_Care_Manual_PCA-1-003116	Full	CST9696 NT16 LA Er diversion brochure PR satisfies this requirement	
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person	LA_Handbook_EN PCCM Program Description CS PCCM 2.0 Chronic Illness Program Management LA_Mental_Health_Substance_Handbook	Full	Addressed by La Handbook EN, PCCM Program Description LA Mental Health Substance Handbook	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	who possesses an average knowledge of health and medicine.				
6.8.1.10	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 patient.	LA_Handbook_EN LA_Mental_Health_Substance_Handbook	Full	Addressed by La Handbook EN, LA Mental Health Substance Handbook	
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:				
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits pg 5-#7	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits pg 5-#7	
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits pg 5-#7	
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits pg 5-#7	
6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits Section 9	
6.8.2.2.2	A network physician assumes responsibility	Utilization Management of	Full	Utilization Management of	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	for the member's care through transfer;	Behavioral Health Benefits		Behavioral Health Benefits Section 9	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits Section 9	
6.8.2.2.4	The member is discharged.	Utilization Management of Behavioral Health Benefits	Full	Utilization Management of Behavioral Health Benefits Section 9	
6.19	**Services for Special Populations**				
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:				
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;				
6.19.1.2	Individuals with intravenous drug use;				
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders;				
6.19.1.4	Substance using women with dependent children;				
6.19.1.5	Children with behavioral health needs in contact with other child serving systems who are not eligible for CSoC;				
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination; and				
6.19.1.7	Adults, 21 years or older, receiving mental health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter the CSoC program.				
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). DHH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those	CS PCCM Medical and Behavioral Case Consult Special Health Care Needs	Full	Special Health Care Needs (pg 1) and CS PCCM Medical and Behavioral Case Consult (pg 2) satisfy the element	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.				
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: • The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, DHH approved, guidelines for SHCN criteria. • MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. • Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. • Members may be identified by DHH and that information provided to the MCO.	CS PCCM Medical and Behavioral Case Consult Special Health Care Needs	Full	CS PCCM Medical and Behavioral Case Consult (pg 3-5) and SHCN identification policies satisfy this requirement	
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan and a person-centered plan of care. The individualized treatment plans must be:	CS PCCM Medical and Behavioral Case Consult Special Health Care Needs	Full	Addressed via CS PCCM Medical and Behavioral Case Consult and SHCN policy	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days	CS PCCM Medical and Behavioral Case Consult	Full	Addressed via CS PCCM Medical and Behavioral Case Consult and SHCN policy	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	following the completion of the initial assessment or annual reassessment.				
6.19.4.2	In compliance with applicable quality assurance and utilization management standards.	CS PCCM Medical and Behavioral Case Consult	Full	Addressed via CS PCCM Medical and Behavioral Case Consult and SHCN policy	
6.19.4.3	SHCN members identified in 6.19.1.6 and 6.19.1.7 must have a person- centered plan of care that includes all medically necessary services including specialized behavioral health services identified in the member's treatment plan.	CS PCCM Medical and Behavioral Case Consult	Full	Addressed via CS PCCM Medical and Behavioral Case Consult and SHCN policy	
6.27	**Care Management**				
6.27.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care	Full	CS PCCM 2.0 satisfies this requirement	
6.27.2 6.27.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care	Full	CS PCCM 2.0 satisfies this requirement	
6.27.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	LA_Acute_Care_Manual_PCA-1-003116 Access Standards and CAC Hours	Full	LA Acute Care Manual 35-36 and Access Standards and CAC Hours satisfy this requirement	
6.27.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination	CS PCCM 2.0 Chronic Illness Program Management CS PCCM Medical and Behavioral Case Consult CS PCCM 2.0 Intensive Opportunity Program Management	Full	Satisfied through CS PCCM 2.0 Chronic Illness Program Management , CS PCCM 2.0 Intensive Opportunity Prog Mgt., and Continuity and Coordination of Behavioral HC	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	for members requiring behavioral health services.	Continuity and Coordination of Behavioral Health Care			
6.27.2.4	Patients with a condition that causes chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	CS PCCM 2.0 Transition of Care	Minimal	CS PCCM 2.0 Transition of Care does not reference this specific element (5 or more ED visits in most recent 12 month period for chief complaint of pain, etc Onsite staff discussed their ED visit trigger process, whereby members with 2 ED visits over a 30 day period are flagged for care management review, but nowhere are ED visits with a chief complaint of pain specifically referenced. It is recommended that the plan's ED trigger process be modified to add ED visits for pain as a specific criterion for review.	UHC: Agree with the recommendation.
6.29	**Care Coordination, Continuity of Care, and Care Transition**				
6.29.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by DHH or DHH's dental benefit program manager. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify	UCSMM 06 21 Out-of-Network Requests and Continuing Care CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care	Full	Satisfied via UCSMM 06 21 Out of Network Requests and Continuing Care , Coordination and Continuity of Behav HC	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by DHH.				
6.29.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	UCSMM 02 14 Interdepartmental and External Entity Coordination CS PCCM 2.0 Intensive Opportunity Program Management Special Health Care Needs	Full	Satisfied via UCSMM 02 14 Interdepartmental and External Entity Coordination	
6.29.2	The MCO shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:				
6.29.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	CS PCCM 2.0 Chronic Illness Program Management CS PCCM 2.0 HEDIS Measure Documentation - Community Care	Full	Satisfied via CS PCCM 2.0 Chronic Illness Program Mgt	
6.29.2.2	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care UCSMM 02 14 Interdepartmental and External Entity Coordination	Full	Satisfied via CS PCCM 2.0 Chronic Illness Program Mgt, Continuity and Coord of Behav HC	
6.29.2.3	Coordinate care for out-of-network services, including specialty care services;	CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care UCSMM 02 14 Interdepartmental and	Full	Satisfied via CS PCCM 2.0 Chronic Illness Program Mgt, Continuity and Coord of Behav HC	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		External Entity Coordination			
6.29.2.4	Coordinate MCO provided services with services the member may receive from other health care providers;	CS PCCM 2.0 Chronic Illness Program Management Continuity and Coordination of Behavioral Health Care UCSMM 02 14 Interdepartmental and External Entity Coordination	Full	Satisfied via CS PCCM 2.0 Chronic Illness Program Mgt, Continuity and Coord of Behav HC	
6.29.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	CS PCCM 2.0 Intensive Opportunity Program Management Special Health Care Needs UCSMM 02 14 Interdepartmental and External Entity Coordination	Full	Addressed via UCSMM 02 14 Interdepartmental and External Entity Coordination	
6.29.2.6	Ensure 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, and other applicable state or federal laws;	HIPAA Regulations Authentication UCSMM 02 14 Interdepartmental and External Entity Coordination	Full	Addressed via HIPAA Regulations Authentication	
6.29.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	CS PCCM 2.0 Transition of Care Discharge Planning UCSMM 06 14 Initial Clinical Review	Full	Addressed via CS PCCM 2.0 Transition of Care and Discharge Planning Policy	
6.29.2.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	CS PCCM 2.0 Transition of Care Discharge Planning UCSMM 06 14 Initial Clinical Review	Full	Addressed via CS PCCM 2.0 Transition of Care and Discharge Planning Policy	
6.29.2.8.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral	Utilization Management of Behavioral Health Benefits	Full	Satisfied via Utilization Mgt of Behavioral HealthBenefits pg 21	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).				
6.29.2.8.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	CS PCCM Medical and Behavioral Case Consult	Full	Satisfied via Utilization Mgt of Behavioral HealthBenefits pg 21 and CS PCCM Medical and Behavioral Case Consult	
6.29.2.8.3.	Coordination with DHH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	LA_BH_Clinical_Workflow_Liaison	Full	Addressed via LA BH Clinical Workflow Liaison	
6.29.2.9	Document authorized referrals in its utilization management system; and	CS PCCM Medical and Behavioral Case Consult	Full	CS PCCM Medical and Behavioral Case Consult	
6.29.2.10	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.	Community and State Louisiana State Specific Job Aid Member Notification of ProviderTermination UCSMM 06 21 Out-of-Network Requests and Continuing Care	Full	Satisfied via Member Notification of Provider Termination policy	
6.29.2.11	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. This may include, but is not limited to, attending court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffings.	LA BH Org Chart	Full	Satisfied via LA BH Org Chart, which specified the court liaison. In addition, calendar documentation of Joint Department Liaison meetings, juvenile judge meetings were provided.	
6.29.2.12	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	Utilization Management of Behavioral Health Benefits	Full	Satisfied via Util Mgt of Behavioral Health Benefits	
6.35	**Continuity for Behavioral Health Care**				
6.35.1	The PCP shall provide basic behavioral health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	LA_Acute_Care_Manual_PCA-1-003116	Full	Satisfied via La Acute Care Manual PCA 1-003116	
6.35.2	The MCO shall establish policies and	Integration of Physical and	Full	Addressed via Integration of	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.	Behavioral Health UM		Physical and Behav Health UM	
6.35.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Triage, Referral and Specialized Clinical Decisions Access Standards and CAC Hours	Full	Triage, Referral and Specialized Clinical Decisions Access Standards and CAC Hours	
6.35.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	Utilization Management of Behavioral Health Benefits	Full	Util Mgt of Behav Health Benefits satisfies this	
6.35.5	The MCO shall include documentation in the member's medical record that attempts are	PCCM Program Description	Full	Addressed via the PCCM Program Description	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	CS PCCM Medical and Behavioral Case Consult			
6.35.6	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, as well as, cost-effectiveness of care.	PCCM Program Description CS PCCM Medical and Behavioral Case Consult CS PCCM Interdisciplinary Case Rounds	Full	Addressed via PCCM program Description	
6.35.7	These procedures must address members 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.	PCCM Program Description CS PCCM Medical and Behavioral Case Consult	Full	Addressed via Behavioral Health Case Mgt/ Care Coordination	
6.35.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	CS PCCM Medical and Behavioral Case Consult LA_Acute_Care_Manual_PCA-1-003116	Full	CS PCCM Medical and Behavioral Case Consult LA_Acute_Care_Manual_PCA-1-003116	
6.35.9 6.35.9.1.1 6.35.9.1.2 6.35.9.1.3 6.35.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co-existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health	Minutes_ADHD_and_ Premature Births PIP Meeting July21_2016draft8.15.16 (2) (2) PCCM Program Description CS PCCM Medical and Behavioral Case Consult	Full	Satisfied via Behavioral Health Case Mgt/ Care Coordination	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	disorders requiring co- management.				
6.35.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	NHS Integrated ACT Proposal_1pg Summary UHC Louisiana	Full	Satisfied via NHS Integrated ACT Proposal, under development. Moreover, staff advised that ADHD integration program already in effect.	
6.35.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Confidential Exchange of Information form	Full	Confidential Exchange of Information form	
6.35.9.1.7	Educating MCO members and providers regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	LA_Handbook_EN LA_Acute_Care_Manual_PCA-1-003116 laMcadManual CST9696_NT16_LA_ERdiversion_brochure_PR	Full	Addressed via La Handbook EN, LA Acute CARE Manual, BH Manual	
6.35.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	PCCM Program Description CS PCCM 2.0 Transition of Care CS PCCM Medical and Behavioral Case Consult	Full	PCCM Program Description/CS PCCM Medical and Behavioral Case Consult satisfy this requirement	
6.35.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	PCCM Program Description CS PCCM 2.0 Transition of Care CS PCCM Medical and Behavioral Case Consult	Full	Addressed via Behavioral Health Case Mgt/Care Coord, CS PCCM Medical and Behavioral Case Consult	
6.35.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	CS PCCM 2.0 CAC Program Management	Full	Addressed via CS PCCM 2.0 CAC Program Mgt Job Aid	
6.35.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	Agenda_9.21.15	Full	Satisfied via NHS Integrated ACT Proposal, under development. Moreover, staff advised that ADHD integration program already in effect.	
6.35.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral	laMcadManual LA_Acute_Care_Manual_PCA-	Full	CS PCCM Medical and Behavioral Case Consult	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	health conditions and referral procedures;	1-003116 C&S PCCM Medical and Behavioral Case Consult		LA_Acute_Care_Manual_PCA-1-003116	
6.35.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CS PCCM 2.0 Chronic Illness Program Management	Full	Staff advised that case management rounds are conducted on a weekly basis	
6.35.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with DHH representatives for the purpose of coordination and communication.	Bayou Health Quality Committee Agenda 3 11 16 (2)	Full	Meeting Agenda –UHC and Bayou Health satisfies requirement	
6.38	**Case Management (CM)**				
6.38.1	The MCO shall develop and implement a case management program through a process which provides that appropriate and medically-related services, social services, and basic and specialized behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate plan that meets the medical, functional, social and behavioral health needs of the member. The MCO shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.	041 UHC 2015 Annual AT 041 UHC 2016 Annual AT 2016 PCCM Program Description Person Centered Care Model (PCCM)Louisiana Addendum	Full	Addressed via 2016 PCCM Program Description, Person Centered Addendum	
6.38.2	Case Management program functions shall include but not be limited to:				
6.38.2.1	Early identification , through active outreach, of members who have or may have special needs;	PCCM Program Description Special Health Care Needs LA Welcome Talking Points LA Behavioral Health Talking Points	Full	PCCM Program Description , special Health Needs address this requirement	
6.38.2.2	Assessment of a member's risk factors;	CS PCCM 2.0 Chronic Illness Program Management Complex Case Management Program	Full	Addressed via CS PCCM 2.0 , Complex Case Mgt Program, Adult and Pediatric HRA	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Adult HRA Pediatric HRA			
6.38.2.3	Education regarding patient-centered medical home and referral to a medical home when appropriate;	2016 PCCM Program Description	Full	Addressed via 2016 PCCM Program Description	
6.38.2.4	Development of an individualized treatment plan, in accordance with Section 6.19.4;	CS PCCM 2.0 Chronic Illness Program Management LA BH Case Management QRG	Full	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG.	
6.38.2.5	Referrals and assistance to ensure timely access to providers;	CS PCCM 2.0 Chronic Illness Program Management Complex Case Management Program	Full	Addressed via CS PCCM 2.0 Chronic Illness Program Mgt	
6.38.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	CS PCCM 2.0 Chronic Illness Program Management	Full	Addressed via CS PCCM 2.0 Chronic Illness Program Mgt	
6.38.2.7	Monitoring;	CS PCCM 2.0 Chronic Illness Program Management Complex Case Management Program	Full	Addressed via CS PCCM 2.0 Chronic Illness Program Mgt	
6.38.2.8	Continuity of care; and	PCCM Program Description CS PCCM 2.0 Chronic Illness Program Management	Full	Addressed via PCCM Program Description, CS PCCM 2.0 Chronic Illness Program Mgt	
6.38.2.9	Follow-up and documentation.	PCCM Program Description CS PCCM 2.0 Chronic Illness Program Management	Full	Addressed via PCCM Program Description, CS PCCM 2.0 Chronic Illness Program Mgt	
6.38.3	Additional Case Management Requirements for the SHCN populations with behavioral health needs as defined in 6.19. A Plan of Care shall be developed by the MCO for this population annually at a minimum and as needed. The plan of care shall list all services and intensity of those services appropriate for the individual. The POC shall be integrated and shall identify both physical	PCCM Program Description CS PCCM 2.0 POC_HAP Documentation - Community Care	Full	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG.	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	and behavioral service needs. Additionally, the POC shall include natural supports needed and referrals to other services.				
6.38.3.1	The MCO shall: • Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately; • Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment; • Ensure members are referred to service providers in accordance with freedom of choice requirement; • Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and • Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.	PCCM Program Description CS PCCM 2.0 Chronic Illness Program Management	Minimal	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG. IPRO reviewed a random sample of twenty (20) care management files, 10 of which were members in behavioral health care management. Review results indicated the following: 9 of the 20 files did not have documentation that an individual needs assessment or a diagnostic assessment was conducted, 7 of the 20 files did not have evidence of a care plan, 7 of 20 files lacked evidence of short and long term treatment objectives, 8 of 20 files lacked evidence of a plan of care for members with Special Health Care Needs. The files not meeting compliance in these areas were **non** behavioral health files. The majority of the members in this group had diagnoses which would indicate some level of care management assessment (e.g. diabetes, renal failure). It is recommended that Care Management staff conduct a focused review of the Care Management system, to clearly identify those members in need of appropriate assessments and develop care plans where appropriate.	UHC: Agree with the recommendation.
6.39	**Case Management (CM) Policies and**				

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	Procedures				
6.39.0	The MCO shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	Person Centered Care Model (PCCM)Louisiana Addendum	Full	Person Centered Care Model LA Addendum addresses the requirement	
6.39.1	A process to offer voluntary participation in the Case Management Program to eligible members;	CS PCCM 2.0 Chronic Illness Program Management Complex Case Management Program	Full	Addressed via CS PCCM 2.0 Chronic Case Mgt	
6.39.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	CS PCCM 2.0 Chronic Illness Program Management Complex Case Management Program	Full	Addressed via CS PCCM 2.0 Chronic Case Mgt	
6.39.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: • Reproductive aged women with a history of prior poor birth outcomes; and • High risk pregnant women.	CS PCCM Healthy First Steps CHW Process Complex Case Management Program	Full	Addressed via CS PCCM Healthy First Steps CHW Process and Complex Case Management Program	
6.39.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	PCCM Program Description Complex Case Management Program	Minimal	This requirement is addressed via CS PCCM 2.0 Chronic Illness Program Mgt, and via LA BH Case Mgt QRG. IPRO reviewed a random sample of twenty (20) care management files, 10 of which were members in behavioral health care management. Review results indicated the following: 9 of the 20 files did not have documentation that an individual needs assessment and diagnostic assessment was conducted, 7 of the 20 files did not have evidence of a care plan, 7 of 20 files lacked evidence of short and long term	UHC: Agree with the recommendation.

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				treatment objectives, 8 of 20 files lacked evidence of a plan of care for members with Special Health Care Needs. The files not meeting compliance in these areas were **non** behavioral health files. The majority of the members in this group had diagnoses which would indicate some level of care management assessment (e.g. diabetes, renal failure). It is recommended that Care Management staff conduct a focused review of the Care Management system, to clearly identify those members in need of appropriate assessments and develop care plans where appropriate.	
6.39.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	CS PCCM 2.0 POC_HAP Documentation - Community Care LA BH Case Management QRG	Full	Addressed via CS PCCM 2.0 Chronic Illness Program Mgt	
6.39.6	Procedures and criteria for making referrals to specialists and subspecialists;	CS PCCM 2.0 POC_HAP Documentation - Community Care Complex Case Management Program	Full	Addressed via CS PCCM 2.0 POC_HAP Documentation-Community Care	
6.39.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	PCCM Program Description CS PCCM 2.0 POC_HAP Documentation - Community Care	Full	PCCM Program Description , POC , addresses this requirement	
6.39.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	PCCM Program Description CS PCCM Interdisciplinary Case Rounds	Full	Addressed via Medical and Behavioral Health Integration	
6.40	**Case Management Reporting Requirements**				
6.40	The MCO shall submit case management	PQ039 UHC Case	Full	PQ039 UHC Case Mgt Report and	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Management Report 2016 Q3 039 UHC 2016 Q3 AT		Attestation satisfy this requirement----	
6.40.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.40.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.40.3	Number of members identified with potential special healthcare needs that self- refer;	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.40.4	Number of members with potential special healthcare needs identified by the MCO;	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.40.5	Number of members in the lock-in program;	PQ039 UHC Case Management Report 2016 Q3	Full	PI145 FWA Quarterly Report satisfies this required—lock in members are specified	
6.40.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	PQ039 UHC Case Management Report 2016 Q3	Full	317 UHC 2016 Report (Q3) satisfies this requirement—PASRR Level II specified.	
6.40.7	Number of members with assessments completed, and	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.40.8	Number of members with assessments resulting in a referral for Case Management.	PQ039 UHC Case Management Report 2016 Q3	Full	PQ039 Report	
6.41	**Chronic Care Management Program (CCMP)**				
6.41.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	Person Centered Care Model (PCCM)Louisiana Addendum	Full	PCCM Louisiana Person Centered Care Model	
6.41.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low	2016 PCCM Program Description	Full	PCCM Program Description Components: Population Based pg 8-9	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.				
6.41.4	The MCO shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	041 UHC 2015 Annual AT 041 UHC 2016 Annual AT Person Centered Care Model (PCCM)Louisiana Addendum	Full	Person Centered C are Model Addendum	
6.41.4.1	Include the definition of the target population;	CS PCCM 2.0 Chronic Illness Program Management	Full	CS PCCM 2.0 Chronic Illness Program Mgt	
6.41.4.2	Include member identification strategies, i.e. through encounter data;	CS PCCM 2.0 Chronic Illness Program Management	Full	CS PCCM 2.0 Chronic Illness Program Mgt	
6.41.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	PCCM Program Description	Full	PCCM Program Description	
6.41.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	PCCM Program Description	Full	PCCM Program Description	
6.41.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	PCCM Program Description	Full	PCCM Program Description Pg 8 042 report Risk Stratification Methodology	
6.41.4.6	Include methods for informing and educating members and providers;	PCCM Program Description	Full	PCCM Program description-pg 8-9	
6.41.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	PCCM Program Description	Full	PCCM Program description-pg 1 Program Purpose	
6.41.4.8	Address co-morbidities through a whole-person approach;	PCCM Program Description	Full	PCCM Program Description policy	
6.41.4.9	Identify members who require in-person case management services and a plan to meet this need;	CS PCCM 2.0 Chronic Illness Program Management	Full	CS PCCM 2.0 Chronic Illness Program MGT Section 4-7	
6.41.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	CS PCCM 2.0 Intensive Opportunity Program Management	Full	CS PCCM 2.0 Intensive Opportunity Program Mgt satisfies this element	

Core Benefits and Services					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
6.41.4.11	Include Program Evaluation requirements.	PCCM Program Description	Full	PCCM Program Description--Annual Program Evaluation	
6.43	**CCMP Reporting Requirements**				
6.43.1	The MCO shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	042 UHC 2016 Q3 AT PQ042 UHC CCMP Report 2016 Q3	Full	PQ042 UHC 2016 Q3	
6.43.2	The CCMP reports shall contain at a minimum:				
6.43.2.1	Total number of members;	PQ042 UHC CCMP Report 2016 Q3	Full	PQ042 UHC 2016 Q3	
6.43.2.2	Number of members in each stratification level for each chronic condition; and	PQ042 UHC CCMP Report 2016 Q3	Full	PQ042 UHC 2016 Q3	
6.43.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	PQ042 UHC CCMP Report 2016 Q3	Full	PQ042 UHC 2016 Q3	
6.43.3 6.43.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	Case Management Program Evaluation - 2015 PCCM UHC CM Evaluation Addendum 3 18 2016 041 UHC 2016 Annual AT	Full	Case Management Program Evaluation - 2015 PCCM UHC CM Evaluation Addendum 3 18 2016 041 UHC 2016 Annual AT	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**				
7.1.1	The MCO must maintain a network that ensures, at a minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan addresses this	
7.1.2	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan addresses this	
7.1.3	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in Appendix SS **– Provider Network – Appointment Availability Standards**. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.				
7.1.4	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 UCSMM 6 21 Out-of-Network Requests and Continuing Care	Full	Addressed via Network Provider Development Mgt Plan and Out of Network Requests	
7.1.6	The MCO shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for cultural competency and linguistic needs, including the member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA_Acute_Care Provider_Manual	Full	Addressed in Network Provider Development and Mgt Plan Policy	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.				
7.2	**Appointment Availability Access Standards**				
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. DHH will monitor the MCO's compliance with these standards through regular reporting as shown in Appendix UU **– Provider Network – Geographic and Capacity Standards**. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	BH Medicaid LA Provider Manual LA_Acute_Care Provider_Manual	Full	Addressed in BH Medicaid Provider Manual –Access to Care section	
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	BH Medicaid LA Provider Manual LA_Acute_Care Provider_Manual	Full	Addressed in BH Medicaid Provider Manual –Access to Care section	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider Manual Pg 33	
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	BH Medicaid LA Provider Manual LA_Acute_Care Provider_Manual	Full	BH Medicaid LA Provider Manual Satisfies this element	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider Manual Pg 33	
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	LA_Acute_Care Provider_Manual	Full	Network Provider Mgt Development Plan pg 3	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their	LA_Acute_Care Provider_Manual	Full	LA Acute Care Manual pg 33	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;				
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	LA_Acute_Care Provider_Manual Continuity and Coordination of Behavioral Health Care	Full	Continuity and coordination of Behav Health Care-Sec 3.5 pg 2	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	BH Medicaid LA Provider Manual LA_Acute_Care Provider_Manual	Full	BH Medicaid Provider Manual pg 19-20	
7.3	**Geographic Access Requirements**				
7.3.0	The MCO shall comply with the following maximum travel time and/or distance requirements, as determined by DHH approved mapping software (*e.g.* GeoAccess). Requests for exceptions as a result of prevailing community standards must be submitted in writing to DHH for approval. Such requests should include data on the local provider population available to the non-Medicaid population.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 4-6	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers • Travel distance for members living in rural parishes shall not exceed 30 miles; and • Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 4-6	
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; if no	Network Provider Development Management Plan with BH 11-4-	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 4-6	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	2016_EQRO2016			
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed in Appendix TT – Network Providers by Specialty Type. DHH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by DHH for this purpose.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Addressed via Network Provider Development Plan-telemedicine not yet in place—being addressed with the LDH	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 5	
7.3.5 7.3.5.1 7.3.5.2	Pharmacies • Travel distance shall not exceed 10 miles in urban parishes; and • Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 5	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers • Travel distance shall not exceed 10 miles in urban areas; and • Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 5	
7.3.7	**Specialized Behavioral Health Providers**	BH Medicaid LA Provider	Full	Network Provider Development	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.3.7.1	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles for 90% of such members.	Manual Network Provider Development Management Plan with BH 11-4-2016_EQRO2016		Management Plan with BH 11-4-2016_EQRO2016 pg 5	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles for 90% of such members.	BH Medicaid LA Provider Manual Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 5	
7.3.7.3	Travel distance to Level III.3/5 Clinically Managed High Intensity Residential shall not exceed 30 miles for 90% of adult members, and shall not exceed 60 miles for adolescent members.	BH Medicaid LA Provider Manual	Full	BH Medicaid LA Provider Manual pg 20	
7.3.7.4	Travel distance to Level III.7 Medically Monitored Intensive Residential co- occurring treatment shall not exceed 60 miles for 90% of adult members.	BH Medicaid LA Provider Manual	Full	BH Medicaid LA Provider Manual pg 20	
7.3.7.5	Travel distance to Level III.7D Medically Monitored Residential Detoxification shall not exceed 60 miles for 90% of adult members.	BH Medicaid LA Provider Manual	Full	BH Medicaid LA Provider Manual pg 20	
7.3.7.6	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles for 90% of members.	BH Medicaid LA Provider Manual	Full	BH Medicaid LA Provider Manual pg 20	
7.3.7.7	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to DHH for approval.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development and Management Plan pg 4	
7.3.7.8	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development and Management Plan pg 5	
7.4.1	Provider to Member Ratios The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for	BH Medicaid LA Provider Manual Network Provider Development Management	Full	Network Provider Development and Management Plan , Provider to Member Ratios	

Provider Network					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	members. Adequate ratios of providers to members can be found in Appendix UU.	Plan with BH 11-4-2016_EQRO2016			
7.5	**Monitoring and Reporting on Provider Networks**				
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	BH Medicaid LA Provider Manual Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA_Acute_Care Provider_Manual	Full	BH Medicaid Provider Manual and LA Acute Care Provider Manual	
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed in Appendix UU. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that will address them. The data in the quarterly GeoAccess reports shall be consistent with provider registry data submitted to DHH by the plans as required in the MCO Systems Companion Guide. The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.	348_GeoAccess_Mapping_4.12.16_UHC Q2 072016 Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	Full	Geo Access Reports, Accessibility analysis reports, and Network adequacy Reports all clearly document provider geographic availability, including any action plans /corrective measures for identifying gaps. A number of gaps exist across various providers, of note are: • FQHCs • Nuclear Medicine • OB/GYNs • Occupational Therapists • Various pediatric specialties IPRO's review of the plan's Provider Gap Narratives provides a comprehensive picture of the gaps that exist across providers, including the above provider types.	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Efforts are clearly being made to contact with providers wherever possible.	
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and Appendix UU. Member linkages to Primary Care providers shall be submitted to DHH weekly as described in the MCO Systems Companion Guide.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	GEO Access Reports are submitted quarterly and include an Accessibility Overview section that includes ratio information in compliance with requirements, approved by the LDH. A PCP Panel report is indicative of plan monitoring to ensure that panel volumes do not exceed allowable thresholds.	
7.6	**Provider Enrollment**				
7.6.1 7.6.1.1	**Provider Participation -** The MCO must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs); all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services) and all providers approved by the DHH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA_Medicaid Payment Appx_Template LA_Medicaid Reg Appendix (Provider) (9.14.15) LA_Facility Participation Agreement_Drafting_tool.11.20.14.FILING LA_FQHC-RHC Participation Agreement_ LA_Medical Group AgreementLA_MGA_Drafting_tool_11.20.14_FILING LA_Small Group AgreementLA_SMGA_Drafting_Tool_11.21.14.FILING	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	
7.6.1.1.1	The MCO must offer a contract to the following behavioral health provider types for specialized behavioral health services for the first twenty-two (22) months after	336_Behavioral_Health_Providers_by_Level_of_Care_Summary_Quarterly_UHC Q2_071816	Full	336_Behavioral_Health_Providers_by_Level_of_Care_Summary_Quarterly_UHC Q2_071816	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	integration. The time period for extending this requirement shall be decided by DHH: • Rural Health Clinics (RHCs); • Local Governing Entities; • Federally Qualified health Centers; • Methadone Clinics pending CMS approval; • Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels I, II.1, II.D, III.1, III.2D, III.3, III.5, III.7, III.7D, IV.D); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Mental Health Rehabilitation (MHR) Agencies; • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).				
7.6.1.2	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 9	
7.6.1.3	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 9	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.6.1.4	The provisions above (7.6.1.2 and 7.6.1.3) do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. This provision also does not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 9	
7.6.1.5	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 9	
7.6.1.6	The MCO shall work with DHH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	Policy - LA 0006.1 Case Management and Support Coordinator Collaboration EQRO Audit 7 6 1 6 RE Annual EPSDT Support Coordination Training Confirmation	Full	Policy - LA 0006.1 Case Management and Support Coordinator Collaboration EQRO Audit 7 6 1 6	
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	UnitedHealthcare Credentialing Plan 2015 2016 UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA Medicaid_CHIP Reg Appendix (Medical	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 10-11	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Subcontractor) 11.2015_Final Clean (3)			
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1) and (2)]. In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 UnitedHealthcare Credentialing Plan 2015 2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 10-11	
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11.2015_Final Clean (3) Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA_Acute_Care Provider_Manual	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	
7.6.3.3	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider. The MCO shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA SPGA Base Agreement	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.6.3.4	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her primary care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(5).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7	**Mainstreaming**				
7.7.1	DHH considers mainstreaming of MCO	Network Provider	Full	Network Provider Development	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Development Management Plan with BH 11-4-2016_EQRO2016 LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11.2015_Final Clean (3)		Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11.2015_Final Clean (3)	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 11	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify DHH in writing	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Minimal	Specific components of this element (developing a written plan within 30 days and notifying DHH in writing) were not explicitly stated in the Network Provider Development Mgt Plan, nor in specific provider contracts. Recommendation: Revise the Network Provider	UHC: Agree with the recommendation.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Development Plan to explicitly include language regarding the development of a written plan within 30 days and notification to LDH. An amendment was subsequently drafted to the Network Provider Development Plan, which explicitly states this element, and was sent to IPRO as a follow up.	
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	Clinician Recruitment Contract	Full	Clinical Recruitment Contract Sec 3.43 Sec 3.7 Sec 4.2	
7.8.2	**Primary Care Provider Responsibilities**				
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:				
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 34	
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.6	Development of plan of care to address risks	LA_Acute_Care	Full	LA_Acute_Care Provider_Manual	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and medical needs and other responsibilities as defined in Section 6.33.	Provider_Manual		Pg 35	
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 36	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 36	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	LA_Acute_Care Provider_Manual	Full	LA_Acute_Care Provider_Manual Pg 35	
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	LA_Acute_Care Provider_Manual	Substantial	EPSDT/Prevention Physical Examinations discusses the need for PCPs to conduct a behavioral health screening, but this only addresses children and young adults, 21 yrs. Other age groups not addressed. The Provider Manual makes reference to identifying behavior health issues as a PCP responsibility, but does not specifically reference screening for various disorders (e.g. depression, anxiety, trauma/ACEs). Recommendation: Staff should amend Provider Manual to include these specific behavioral screenings, and also insure that these activities	UHC: Agree with the recommendation.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				are tracked on Medical Record Audit Tools, for monitoring purposes going forward. The plan is in process of revising their Provider Manual accordingly.	
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.				
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 14-15	
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider Manual, pg 33-37, 62	
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in Appendix TT who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	Substantial	Geo Access Reports, Accessibility analysis reports, and Network adequacy Reports all clearly document provider geographic availability, including any action plans /corrective measures for identifying gaps. A number of gaps exist across various providers, of note are: • FQHCs • Nuclear Medicine • OB/GYNs • Occupational Therapists • Various pediatric specialties IPRO's review of the plan's Provider Gap Narratives provides a comprehensive picture of the gaps that exist across providers,	UHC: Agree with the recommendation.

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				including the above provider types. Efforts are clearly being made to contract with providers wherever possible.	
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the MCO does not meet the access standards specified in the Contract.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Gap Analysis_UHC 2015 Q3 Attachment GEO Access Report UHC 2015 Q3 Network Adequacy Report.UHC 2015 Q3 Network Adequacy.UHC 2015 Q3 Attestation	
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. MCO must establish access to the following within their network of hospitals: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 15-19	
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 16	
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 16	
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 18 Tertiary Care	
7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the	Women's Health PP 2015 (BH Update) EQRO 2016 LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider manual pg 51-52	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	member's PCP if that provider is not a women's health specialist.				
7.8.6.1	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.	LA_Member Handbook EQRO 2016 LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider manual pg 51-52	
7.8.6.2	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.	LA_Acute_Care Provider_Manual	Full	LA Acute Care Provider Manual Chapter 2 pg 23 Chapter 5 Pg 51-52	
7.8.6.4	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	LA_Acute_Care Provider_Manual	Full	LA Acute Csre Provider Manual pg 51-52	
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in	LA_Acute_Care Provider_Manual	Full	Network Provider Development Mgt Plan	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	PCCM Program Description			
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	LA_Acute_Care Provider_Manual	Full	Network Provider Development Mgt Plan pg 22-23	
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the state.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 LA_Acute_Care Provider_Manual	Full	Network Provider Development Mgt Plan pg 22-23	
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.				
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016.	
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 23-24	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for	Network Provider Development Management Plan with BH 11-4-	Full	Network Provider Development Mgt Plan pg 22-23	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	2016_EQRO2016			
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall work with the existing network of behavioral health providers to ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring including mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities (LGEs) for the provision of Medicaid services.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 348_GeoAccess_Mapping_4.12.16_UHC Q2 072016	Full	Network Provider Development Mgt Plan pg 24-25	
7.8.14.4	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing required peer services (i.e., required peer services such as Youth Support Training and Parent Support Training), in lieu of peer services, and peers certified to serve as qualified providers of other state plan/waiver services (including, but not limited to, PSR or CPST).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 25	
7.8.14.5	The MCO shall ensure that within the provider network, members enrolled in Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 25	
7.8.14.7	The MCO shall have a fully operational network of behavioral health crisis response	Network Provider Development Management	Full	Network Provider Development Mgt Plan pg 25	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. The community- based crisis response system may include, but is not limited to, an on-call, 24-hour crisis hotline, warm line, crisis counseling, behavioral health management and intervention, mobile crisis teams, and crisis stabilization in an alternative settings. If shortages in provider network sufficiency are identified by DHH, the MCO shall conduct outreach efforts approved by DHH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.	Plan with BH 11-4-2016_EQRO2016 Access Standards and CAC Hours Authorizing Services for In Network and OON for Practitioners-Facilities			
7.8.14.9	The MCO shall require behavioral health providers to screen for basic medical issues, such as utilizing the healthy living questionnaire 2011 or the PBHCI medical screening short form.	laBayouHlthProvTraining_BH orientation slides	Full	Network Provider Development Mgt Plan pg 26	
7.9	**Network Provider Development Management Plan**				
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to DHH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop,	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 27	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.206):				
7.9.1.1	Anticipated maximum number of Medicaid members;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 27	
7.891.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 27	
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 27	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 29	
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 29	
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 29	
7.9.2.1	Assurance of Adequate Capacity and Services	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 2-7	
7.9.2.2	Access to Primary Care Providers	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 30	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.9.2.3	Access to Specialists	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 30	
7.9.2.4	Access to Hospitals	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Mgt Plan pg 30	
7.9.2.5	Access to Behavioral Health Services	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 30	
7.9.2.6	Timely Access	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 31-32	
7.9.2.7	Service Area	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 32	
7.9.2.8	Other Access Requirements: Direct Access to Women's Health , Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 32	
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 34-35	
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to DHH quarterly, or upon material change (as defined in the Glossary) or upon request.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 348_GeoAccess_Mapping_4.12.16_UHC Q2 072016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:				

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.2	Monitor network compliance with policies and rules of DHH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.3	Evaluate the quality of services delivered by the network;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Authorizing Services for In Network and OON for Practitioners-Facilities	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.7	Provide training for its providers and maintain records of such training;	BH Annual Training Plan_2-18-16 Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and	Network Provider Development Management Plan with BH 11-4-	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	appropriate;	2016_EQRO2016		Pg 36	
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from DHH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 36	
7.9.7	MCO Network Development and Management policies shall be subject to approval by DHH, Medicaid Managed Care Section and shall be monitored through operational audits.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 37	
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to DHH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 37-38	
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 37-38	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following	BH Policy C.01 Types of Clinicians and Eligibility	Full	Network Provider Development Management Plan with BH 11-4-	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Criteria		2016_EQRO2016 pgs 37-38	
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 37-38	
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to DHH quarterly by contract year, upon material change of the network, or upon request;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 348_GeoAccess_Mapping_4.12.16_UHC Q2 072016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 37-38	

	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include:
	  • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services;
	  • Specialized behavioral health service needs of members; and
	  • Growth trends in eligibility and enrollment, including:
	  o Current and anticipated numbers of Title XIX and Title XXI eligibles; and
	  o Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the
		BH Policy N.02 Network Development and Enhancement
		
		Network Provider Development Management Plan with BH 11-4-2016_EQRO2016
			Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 38	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	enrolled population by region; best practice approaches; and network and contracting models consistent with DHH goals and principles.				
	• Accessibility of services, including: o The number of current qualified specialized behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; o The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; o Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.	BH Provider directory www.liveandworkwell.com	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 38	
7.9.8.3	The MCO shall submit to DHH as part of its annual Network Development and Management Plan, and upon request of DHH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg-38	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.				
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 39	
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as:	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 39	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• Includes specific specialized behavioral health services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.				
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pgs 39-40	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.				
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 40	
7.11	**Material Change to Provider Network**				
7.11.1	The MCO shall provide written notice to DHH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract, including but not limited to the following: • Any change that would cause more than	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.				
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 41-42	
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 41-42	
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg41-42	
7.11.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, DHH will expedite the approval process.				
7.11.6	The MCO shall notify the DHH/BHSF/Medicaid Managed Care Section	Network Provider Development Management	Full	Network Provider Development Management Plan with BH 11-4-	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	Plan with BH 11-4-2016_EQRO2016		2016_EQRO2016 pg 41-42	
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Pg 41	
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: Provide written notice to DHH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 41	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	treatment in an area where another provider of equal service ability is not available as required by access standards approved by DHH.				
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 Authorizing Services for In Network and OON for Practitioners-Facilities	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 36	
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to DHH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 41-42	
7.11.8.4	If a provider loss results in a material gap or	Network Provider	Full	Network Provider Development	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	behavioral health network deficiency, the MCO shall submit to DHH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.	Development Management Plan with BH 11-4-2016_EQRO2016		Management Plan with BH 11-4-2016_EQRO2016 pg 41-42	
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by DHH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	
7.12	**Coordination with Other Service Providers**				
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 44 Coordination with other service providers	
7.13	**Provider Subcontract Requirements**				
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 45-47	
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**				
7.14.1	The MCO must have a written credentialing	UnitedHealthcare	Full	UnitedHealthcare Credentialing	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to DHH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	Credentialing Plan 2015 2016 UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum BH Policy pg 2		Plan 2015 2016	
7.14.1.1	Prior to subcontracting, the MCO shall follow DHH policy in requiring agencies offering Mental health rehabilitation services (CPST, PSR and/or CI), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation or proof that the applicant applied for accreditation and paid the initial application fee for one of the national accreditation organizations listed below. New agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).	BH Policy pg 2	Full	BH Policy pg 2	
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	UnitedHealthcare Credentialing Plan 2015 2016 UnitedHealthcare Credentialing Plan FAQs UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum	Full	UnitedHealthcare Credentialing Plan 2015 2016 pg 20	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the	UnitedHealthcare Credentialing Plan 2015 2016	Full	UnitedHealthcare Credentialing Plan State and Federal Regulatory	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum		Addendum pg 22	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	UnitedHealthcare Credentialing Plan 2015 2016 UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum 19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Summary Young_Org19523_Medicaid_HMO Org19523_CommendableCert_Medicaid_HMO	Full	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum pg 22	
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum	Full	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum pg 22	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum	Full	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum pg 22	
7.14.5.2	Submit on the weekly electronic Provider Directory to DHH or DHH's designee; or	Submit on the weekly electronic Provider directory to DHH or DHH's designee	Full	Weekly Electronic Provider Directory submission to DHH or DHH designee	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	UnitedHealthcare Credentialing Plan 2015 2016	Full	UnitedHealthcare Credentialing Plan 2015 2016 pg 6	
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing	UnitedHealthcare Credentialing Plan 2015 2016	Full	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements.	UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum 102 DelCredOversight Rev_Final 01 06 16 LA Delegation Agreement Template 10-05-06_092916		Louisiana	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by DHH in advance.	BH Policy pg 2	Full	BH Policy pg 2	
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.	Escalation Process for Provider Adds and New Contracts	Full	Escalation Process for Provider Adds and New Contracts	
7.14.9	The MCO shall notify DHH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	Fraud and Abuse Detection and Prevention FINAL	Full	Fraud and Abuse Detection and prevention pg 5	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	UnitedHealthcare Credentialing Plan 2015 2016	Full	United HealthCare Credentialing Plan 2015-16 pg 10	
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	UnitedHealthcare Credentialing Plan 2015 2016 UnitedHealthcare Credentialing Plan State and Federal Regulatory Addendum	Full	United HealthCare Credentialing Plan 2015-16 pg 10	
7.14.12	The MCO shall develop and implement a mechanism, subject to DHH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty	SOP_LA Quality deficiencies which result in provider termination QOC Investigation Policy Exhibit B Level Descriptor and	Full	SOP_LA Quality deficiencies which result in provider termination QOC Investigation Policy Exhibit B Level Descriptor and IAP Codes-5-23.16	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	(30) days from the date the Contract is signed and at the time of any change.	IAP Codes-5-23.16 QOC Investigation Policy - Exhibit A - LA Medicaid Regulatory Requirements (10-17-16) QOC Investigation IAP and Disciplinary Action Policy (5-23-16)		QOC Investigation Policy - Exhibit A - LA Medicaid Regulatory Requirements (10-17-16) QOC Investigation IAP and Disciplinary Action Policy (5-23-16)	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	UnitedHealthcare Credentialing Plan 2015 2016 QOC Investigation IAP and Disciplinary Action Policy (5-23-16)	Full	UnitedHealthcare Credentialing Plan 2015 2016 QOC Investigation IAP and Disciplinary Action Policy (5-23-16)	
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.				
7.16	**Provider-Member Communication Anti-Gag Clause**				
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	
7.16.1.2	Any information the member needs in order	Network Provider	Full	Network Provider Development	

Provider Network					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	to decide among relevant treatment options;	Development Management Plan with BH 11-4-2016_EQRO2016		Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.				
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016	Full	Network Provider Development Management Plan with BH 11-4-2016_EQRO2016 pg 47 Anti Gag	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
8.1	**General Requirements**				
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The MCO shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed by: UCSMM 06 13 Non-Clinical Intake and Initial Screening UCSMM 06 19 Information Based Clinical Review Policy and in the : UCSMM 06 10 Clinical Review Criteria UCSMM 06 14 Initial Clinical Review UCSMM 06 15 Peer Clinical Review UCSMM 06 16 Initial Review Timeframes UCSMM 06 18 Initial Adverse Determination Notice UCSMM 06 21 Out-of-Network Requests and Continuing Care UHC CP LA Medicaid Utilization Management Policy. It is also documented in the Utilization Management of Behavioral Health Benefits. All P/P were reviewed by the MCO within the compliance review period. Per interview, when BH benefits were carved in December 1, 2015, all PH and BH P/P were integrated. Also, since Optum is a division within UHC, Medical Management P/P are applicable to all requirements.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include				

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	medical management criteria and practice guidelines that:				
8.1.2.1	Are adopted in consultation with contracting health care professionals;	Clinical Policies Guidelines Development and Approval, Dissemination Use Young_Org19523_Medicaid_HMO Org19523_CommendableCert_Medicaid_HMO UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 1) and (Optum) Clinical Policies Guidelines Development and Approval, Dissemination Use (p. 2) policy	
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	Clinical Policies Guidelines Development and Approval, Dissemination Use Disease_Specific_Guidelines_Grid Agenda_PAC_2016_07 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by: The (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 1) policy and the (Optum) Clinical Policies Guidelines	
8.1.2.3	Are considerate of the needs of the members; and	Clinical Policies Guidelines Development and Approval, Dissemination Use Disease_Specific_Guidelines_Grid Agenda_PAC_2016_07 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 2, 4) policy and the (Optum) Clinical Policies Guidelines Development and Approval, Dissemination Use (Section 4.8, p. 4) policy.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	Clinical Policies Guidelines Development and Approval, Dissemination Use Disease_Specific_Guidelines_Grid Agenda_PAC_2016_07	Full	Requirement addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 1) policy and the (Optum) Clinical Policies Guidelines Development and Approval, Dissemination Use (Section 1.6, p. 3) Policy	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		UCSMM 06 10 Clinical Review Criteria		All guidelines were approved by the Medical Technology Assessment Committee (MTAC) and National Medical Care Management Committee (NMCMC) in May 2016 The PAC Meeting Agenda – Guidelines were approved by the PAC July 2016	
8.1.3	The policies and procedures shall include, but not be limited to:				
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 14 Initial Clinical Review (p.2) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (p. 1, 2).	
8.1.3.2	The data sources and clinical review criteria used in decision making;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 14 Initial Clinical Review (p.2) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (Section V.D.1.f, p. 9 and Section V.G, p. 14).	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 14 Initial Clinical Review (p.2) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (Section V.G. 2, p. 15).	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review	Full	Requirement addressed by: The (Physical Health) UCSMM 06 15 Peer Clinical Review policy and the UHC CP LA Medicaid Utilization Management Policy.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Criteria		It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V.A.5,, p. 4).	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	UCSMM 06 10 Clinical Review Criteria	Full	Requirement is addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 2) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (p. 9) policy. Consistent application further addressed by: Standard Operating Procedure UCS Annual Milliman Care Guidelines Interrater Reliability 2016 MCG IRR Results Combined Per interview, while training and testing protocols are in place, not enough time had elapsed to submit annual testing results for BH.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical Health) UCSMM 06 19 Information Based Clinical Review policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V.G, p. 14) policy.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical Health) UCSMM 06 19 Information Based Clinical Review (p. 2) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (Section V.R, p. 28).	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed in the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits (p. 2) policy.	
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed by the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits (Section M.6, p. 21).	
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed by the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits (Section M.7, p. 21) policy.	
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed by the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (Section M.8, p. 22).	
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed by the UHC CP LA Medicaid Utilization Management Policy. It Is also addressed in the Utilization Management of Behavioral Health Benefits policy (Section M.9, p. 22).	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	Clinical Policies Guidelines Development and Approval, Dissemination Use Disease_Specific_Guidelines_ Grid Agenda_PAC_2016_07	Full	Requirement addressed by: The following statement from the MCO. “United Healthcare uses nationally approved standards for Clinical Practice Guidelines, as do the other MCOs.” The Disease-Specific Guideline Grid	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Statement 8.1.4		and PAC Agenda July 2016 demonstrates adoption of nationally approved guidelines – physical and behavioral health (Optum) Clinical Policies Guidelines Development and Approval, Dissemination Use (Section 1.3, p. 2)	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	UHC CP LA Medicaid Utilization Management Policy-final 062416 Provider Portal Landing Page LA_Acute_Care_Manual	Full	Dissemination to members: As per policy UCSMM 06 10 Clinical Review Criteria (p. 2,4), all adverse determination letters state the clinical review criteria upon which the non-certification determination was made are available upon request by the consumer or provider." Dissemination to providers: The requirement is addressed as cited immediately above, and by: Louisiana Acute Care Provider Manual (Chapter 17 Clinical Practice Guidelines, p. 103) Provider Portal Landing Page (screenshot)	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	Provider Portal Landing Page LA_Acute_Care_Manual Example 1 Disease_Specific_Guidelines_Grid	Full	Compliance with guidelines is assessed as part of medical record review audits, whereby providers are informed they are expected to achieve a passing score of 90% (Louisiana Acute Care Provider Manual, p. 40-41, 45, 47, 68). A sample provider scorecard was submitted which lists physical and behavioral health guidelines, period performance, target performance, whether targets were Met or Not Met, and the estimated quality bonus for each target Met.	

Utilization Management					
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				At interview, the MCO also submitted the P/P Louisiana Medicaid Provider Site and Desktop Audits describing provider monitoring by Optum personnel, and the Louisiana Bayou Audit Summary Report demonstrating compliance by all providers.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 1-2) policy. External clinical review criteria examples were provided – MCG Care Guidelines and InterQual. Internal criteria Medical Policy, Coverage Determination Guidelines, and Utilization Review Guidelines as outlined in the UM Program Description were provided onsite. Behavioral Health review criteria examples were provided – UHC LA Level of Care Guidelines (Provider Manual), Psychological and Neuropsychological Testing Guidelines, ASAM Criteria, and State-specific Guidelines.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed as cited at 8.1.6.	
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed as cited at 8.1.6.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed as cited at 8.1.6.	
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 14 policy. Initial Clinical Review (p. 1). States that RNs, LPNs or LVNs with access to physicians can determine whether a review request can be approved/certified, but will not make clinical adverse decisions. The plan requires that the peer clinical reviewer will hold a current license in the same category as the treating provider.	
8.1.7	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed as cited in Policy 8.1.5. Monitoring of consistent application addressed as cited in 8.1.3.5.	
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical Health) UCSMM 06 19 Information Based Clinical Review (p. 1, 2) policy and the UHC CP LA Medicaid Utilization Management Policy.	
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information	Full	Requirement addressed as cited in Policy 8.1.8, with time allowed beyond what is required for both physical and behavioral health requests for review.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	Based Clinical Review		As per the P/P Information-Based Clinical Review, if a provider indicates submission of all information is available, a clinical review must be completed. If information is requested but not forthcoming, and the timeframe for a standard pre or post service review has been extended, the consumer is given 45 days to provide the information. As per UM of BH Benefits, the timeframe to make a determination is suspended when a Request for Information letter is sent, and the suspension ends upon receipt of information, or 48 hours from the time the letter was sent.	
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO shall provide UM staff specifically assigned to: Specialized behavioral health services, and PSH to ensure appropriate authorization of tenancy services.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	The following physical health P/P addresses the qualifications of clinical review staff: UCSMM 06 14 Initial Clinical Review UCSMM 06 15 Peer Clinical Review The following behavioral health P/P restates the contract requirement regarding 'sufficient, qualified staff:' Utilization Management of Behavioral Health Benefits (Section IV, p. 2 and Section V.D, p. 8). At interview, the MCO submitted four organizational charts demonstrating corporate and Louisiana staffing: C & S (Community and State) Clinical Coverage Review Medical Directors, Clinical Coverage Review Prior Auth Nurses, ICM/UM Medical Directors, ICM/UM Nurses.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.1.11	The MCO shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	UHC CP LA Medicaid Utilization Management Policy-final 062416 Louisiana Medicaid Level of Care Guidelines_PRTF UCSMM 06 10 Clinical Review Criteria UCSMM 01 11 Document Oversight and Adherence	Full	Requirement addressed by the (Physical Health) UCSMM 01 11 Document Oversight and Adherence (p. 4, 15-16) policy. It is also addressed in the Optum By United Behavioral Health, Louisiana Medicaid Level of Care Guidelines (Psychiatric Residential Treatment Facility – PRTF) policy (p. 6)	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited in Policy 8.1.6.4. Medical necessity is included when qualifications to approve/certify requests, and render adverse determinations, are discussed.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited for 8.1.6.4.	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited for 8.1.6.4.	
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	Credentialing_of_Optum_Clinical_Personnel UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed by: (Physical Health) UCSMM 06 15 Peer Clinical Review (p.2) policy. "Staff members will comply with the established requirements or the more stringent/restrictive of applicable accreditation, state/federal law, contract or government program requirements."	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				The behavioral health P/P Credentialing of Optum Clinical Personnel also makes reference to current and valid unrestricted licenses across professions. At interview, the MCO Medical Director expanded on the policy by explaining a provider may have been disciplined for reasons not related to patient care without restriction of license.	
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	UCSMM 06 15 Peer Clinical Review LA_BH_Clinical_Workflow_Peer Review	Full	Requirement addressed as cited for 8.1.6.4. The physical health P/P UCSMM 06 15 Peer Clinical Review states "Standard operating procedure will define the use of contracted board-certified consultants and a list of contracted board-certified consultants will be maintained (p.2). The behavioral health P/P Credentialing of Optum Clinical Personnel also notes Peer Reviewers are to be board-certified to practice as a psychiatrist or addictionolgist (p. 3).	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed by the (Physical Health) UCSMM 06 10 Clinical Review Criteria (p. 4) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed by the Utilization Management of Behavioral Health Benefits Policy (Section IV, p. 2).	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.				
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 02 12 Performance Assessment and Incentives	Full	Requirement addressed by: UCSMM 02 12, Performance Assessment and Incentives and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section IV, p. 2).	
8.4	**Service Authorization**				
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed in the UCSMM 06 16 Initial Review Timeframes and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section IV, p. 2, p. 33-40).	
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Kliebert and Wells v. Kliebert for initial and continuing authorization of services that include, but are not limited to, the following:	UCS Annual Milliman_IRR_SOP__Final TSC 2016 MCG IRR Results combined UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed as cited at 8.1.1. The behavioral health P/P Utilization Management of Behavioral Health Benefits (Section 1, p. 1) specifically cites Chisholm v. Kliebert and Wells vs. Kleibert.	
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed in the (Physical Health) UCSMM 06 19 Information Based Clinical Review (p. 2) and the UHC CP LA Medicaid Utilization Management Policy.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	timely manner;			It is also addressed in the Utilization Management of Behavioral Health Benefits (p. 18 as per 8.1.8 and p. 28).	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Monitoring of consistent application addressed as cited at 8.1.3.5. Consultation with requesting provider addressed by the (Physical Health) UCSMM 06 15 Peer Clinical Review and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V.D. 2, p. 10)	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 10 Clinical Review Criteria	Full	Requirement addressed as cited at 8.1.17.	
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 13 Non-Clinical Intake and Initial Screening	Full	Requirement addressed in the (Physical Health) UCSMM 06 13 Non-Clinical Intake and Initial Screening policy (p. 3) and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. A. 1, p. 3) and the Member Handbook (p. 22, 55)	
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 13 Non-Clinical Intake and Initial Screening	Full	Requirement addressed in the(Physical Health) UCSMM 06 13 Non-Clinical Intake and Initial Screening (p. 3) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits Policy	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				(Section T.3, p. 30)	
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	UCSMM 06 13 Non-Clinical Intake and Initial Screening	Full	Requirement addressed in the UCSMM 06 13 Non-Clinical Intake and Initial Screening policy (p. 3)	
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed in the (Physical Health) UCSMM 06 14 Initial Clinical Review (p. 3) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (p. 31)	
8.4.4	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed by: (Physical Health) UCSMM 06 14 Initial Clinical Review (p. 4) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (p. 2)	
8.4.4.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed in the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy (p. 2, 4, 8, 9).	
8.4.4.2	Concurrent utilization reviews are administrative in nature and should not be reported to DHH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed in the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits policy (Section V. F. 4, p. 13).	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	psychiatric hospital may be admitted by hospital staff. However, DHH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.				
8.4.4.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized	UHC CP LA Medicaid Utilization Management Policy-final 062416	Full	Requirement addressed in the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits policy: Table 1C. Post-Stabilization – Authorizations and Actions (Denials) (p. 35) Table 2A. Expedited Concurrent Coverage Determinations (Authorizations) (p. 36) Table 2B. Expedited Concurrent Non-Coverage Determinations (Denials) (p. 37) At interview, BH personnel expanded on the requirement by explaining 99.9% of admissions follow presentation to a facility, or intervention in the community, with screening documentation less of an issue; post-stabilization, expedited and standard concurrent timeframes apply, as per the submitted documentation.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.				
8.4.4.4	Certification of Need for PRTFs				
8.4.4.4.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.				
8.4.4.4.2	The MCO shall ensure LMHPs are included in the team responsible for certification and	UHC CP LA Medicaid Utilization Management	Full	Requirement addressed by the Standard Operating Procedure	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	Policy-final 062416		Certification/ Recertification of PRTF Services in Louisiana policy.	
8.4.4.4.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	SOP Certification-Recertification PRTF	Full	Requirement addressed by the Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy.	
8.4.4.4.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	SOP Certification-Recertification PRTF	Full	Requirement addressed by the Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy.	
8.4.4.4.5	In addition to certifying the need, the MCO shall: • Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. • Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility. • Upon completion of the certification of need, if the PRTF is approved, within 48 hours, the MCO shall notify in writing, the provider requesting the certification of the results. If denied, the MCO shall notify the provider requesting the certification immediately and, within 48 hours, provide written notification to the provider requesting the certification of the results. The notification shall include whether or not an alternative community services plan	Louisiana Medicaid Level of Care Guidelines_PRTF PQ188 Report SOP Certification-Recertification PRTF	Full	Requirement addressed by the Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy Monitoring addressed by: PQ188 Report – Behavioral Health Reporting At interview, BH personnel added that when necessary and possible, out-of-network PRTF placement is obtained, as opposed to maintaining waiting lists.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	is appropriate, the right of the member to appeal, and the process to do so. • Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. • Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. • Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. • Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.				
8.4.5	At such time Therapeutic Foster Care (TFC) is added to the Medicaid benefit, the MCO shall work with DHH to develop prior authorization and concurrent utilization review for that service. MCOs may use the Service Definition Manual or other approved Medical Necessity Criteria for Therapeutic Group Homes and other residential levels of care.	Louisiana Medicaid Level of Care Guidelines_Therapeutic Foster Care	Full	Requirement addressed by: Louisiana Medicaid Level of Care Guidelines – Therapeutic Foster Care	
8.5	**Timing of Service Authorization Decisions**				
8.5.1	**Standard Service Authorization**				
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Substantial	Requirement addressed by: The (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits: Table 3A. Standard Pre-Service Coverage Determinations – Outpatient (Authorizations) (p. 38) – 14 days Table 3B. Standard Pre-Service Non-Coverage Determinations (Denials) (p. 39) – 14 days Recommendation	UHC: Agree with the recommendation.

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				The physical health P/P notes 80% of standard determinations should be made within 2 business days of receipt of information. The behavioral health P/P notes only a 14 calendar day requirement from receipt of request, and should include TAT goals. At interview, the MCO notes the Medical Management P/P prevails, and the required language will be added to the Behavioral Health P/P.	
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed by the (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy: Table 2A. Expedited Concurrent Coverage Determinations (Authorizations) (p. 37) – 72 hours Table 2B. Expedited Concurrent Non-Coverage Determinations (Denials) (p. 38) – 72 hours <u>Recommendation</u> Per the behavioral health P/P, concurrent reviews are completed within 72 hours; policies should be consistent with requirements, and include TAT goals.* *As cited at 8.4.3, the PQ 188 Behavioral Health Report tracks concurrent reviews completed within one business day and two business days.	
8.5.2	**Expedited Service Authorization**				

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed by: The (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy: Table 1A. Expedited Pre-Service Coverage Determinations (Authorizations) (p. 33) Table 1B. Expedited Pre-Service Non-Coverage Determinations (Denials) (p. 34)	
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to DHH a need for additional information and how the extension is in the member's best interest.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed by the (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (p. 32 – footnote)	
8.5.3	**Post Authorization**				
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed by the (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 6) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy: Table 4A. Post-Service Coverage Determinations (Authorizations) (p. 39) Table 4B. Non-Urgent Post-Service Non-Coverage Determinations (Denials) (p. 40)	
8.5.3.2	The MCO shall not subsequently retract its	UHC CP LA Medicaid	Full	Requirement addressed by the	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes		(Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 6) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. A. 11, p. 6) policy	
8.5.4	**Timing of Notice**				
8.5.4.1	**Notice of Action**				
8.5.4.1.1	**Approval [Notice of Action]**				
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or 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 documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Substantial	Requirement addressed by the (Physical Health) UCSMM 06 16 Initial Review Timeframes (p. 6) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits policy:– Tables 1A through 4B as cited previously in this review (p. 33-40). During file review, In all instances except one, the Issuance of Notice of Action is included within the relevant time period to render the determination. Regarding Table 1C Post-Stabilization Authorizations and Actions, the Delivery of Verbal Notice is made within one hour, and the Issuance of Written Notice is made within one day.	UHC: Agree with the recommendation.
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed as cited for 8.5.4.1.1.1.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.				
8.5..4.1.2	**Adverse [Notice of Action]**				
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 18 Initial Adverse Determination Notice	Full	Requirement addressed by the (Physical Health) UCSMM 06 18 Initial Adverse Determination Notice (p. 4) policy and the LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. A. 2, p. 3 and V. T. 2, p. 29) policy. 10/10 files reviewed met all requirements regarding adverse determinations and notifications.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or 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 documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 16 Initial Review Timeframes	Full	Requirement addressed as cited for 8.5.4.1.1.1 (approvals).	
8.5.4.1.3	**Informal Reconsideration**				
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed by the (Physical Health) UCSMM 06 15 Peer Clinical Review (p. 2-3, 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. A. 5, p. 4) policy.	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited for 8.5.4.1.3.1.	
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited for 8.5.4.1.3.1.	
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 15 Peer Clinical Review	Full	Requirement addressed as cited for 8.5.4.1.3.1.	
8.5.4.2	**Exceptions to Requirements**				
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	UHC CP LA Medicaid Utilization Management Policy-final 062416 LA_Acute_Care_Manual UCSMM 04 11 Consumer Safety **STATEMENT:** Unless otherwise stated, the plan does NOT need a preauthorization for services.	Full	Requirement addressed in the (Physical and behavioral health) UCSMM 04 11 Consumer Safety (p. 1, 4) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. P, p. 26) policy and the Louisiana Acute Care Provider Manual (p. 11)	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	LA_Acute_Care_Manual UCSMM 04 11 Consumer Safety	Full	Requirement addressed by: UCSMM 04 11 Consumer Safety (p. 4) and the Louisiana Acute Care Provider Manual (p. 14, 62)	
8.5.4.2	The MCO shall not require service	LA_CAID_PA_PCA15905	Full	Requirement addressed by the	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	authorization or referral for EPSDT screening services.	LA_Acute_Care_Manual		Louisiana Acute Care Provider Manual (p. 11) and the UHC Advance Notification/Prior Authorization Requirements for Louisiana policy	
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	UHC CP LA Medicaid Utilization Management Policy-final 062416 LA_Acute_Care_Manual UCSMM 06 21 Out-of-Network Requests and Continuing Care_clean version	Full	Requirement addressed by the UCSMM 06 21 Out-of-Network Requests and Continuing Care (p. 3) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. B, p. 7) policy.	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	UCSMM 06 21 Out-of-Network Requests and Continuing Care_clean version LA_Acute_Care_Manual	Full	Requirement addressed as cited for 8.5.4.2.	
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	LA_Acute_Care_Manual	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 14)	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	LA_Acute_Care_Manual	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 14 optical services)	
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	LA_Acute_Care_Manual UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 62) and by the UCSMM 06 14 Initial Clinical Review (p. 4) policy	
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	LA_Acute_Care_Manual UCSMM 06 14 Initial Clinical Review	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 62) and the UCSMM 06 14 Initial Clinical Review (p. 4) policy	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions	LA_Acute_Care_Manual	Full	Requirement addressed by: Louisiana Acute Care Provider	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	within one (1) business day of admission.	UCSMM 06 14 Initial Clinical Review		Manual (p. 5 – within 48 hours) and the UCSMM 06 14 Initial Clinical Review (p. 4) policy	
8.11	**Medical History Information**				
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical Health) UCSMM 06 19 Information Based Clinical Review policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. G, p. 14) policy.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed as cited for 8.1.8 and 8.1.9, and further addressed by the UCSMM 06 19 Information Based Clinical Review (p. 5) policy.	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	UHC BH Group Agreement UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical health) UCSMM 06 19 Information Based Clinical Review (p. 5) policy and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits (Section V. I, specifically p. 18) policy.	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by DHH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	UHC BH Group Agreement UHC CP LA Medicaid Utilization Management Policy-final 062416 UCSMM 06 19 Information Based Clinical Review	Full	Requirement addressed by the (Physical health) UCSMM 06 19 Information Based Clinical Review (p. 5) policy.	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**				
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and	QOC Investigation IAP and Disciplinary Action Policy QOC Investigation Policy -	Full	Requirement addressed by the QOC Investigation IAP and Disciplinary Action Policy and for physical and behavioral health by the UHC	

Utilization Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	analyze utilization data to identify utilization and/or quality of care issues.	Exhibit A - LA Medicaid Regulatory Requirements (10-17-16) (2) (2) QOC Investigation Policy Exhibit B Level Descriptor and IAP Codes-5-23.16 UHC Adverse Incident Critical Incident Policy and Procedure_revised 10.2016rev. (2) LA_Acute_Care_Manual		Adverse Incident Critical Incident Policy and Procedure It is also addressed in the Louisiana Acute Care Provider Manual (p. 67) (Physical and behavioral health) Example 1 – Provider Scorecard	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	QOC Investigation IAP and Disciplinary Action Policy QOC Investigation Policy - Exhibit A - LA Medicaid Regulatory Requirements (10-17-16) (2) (2) QOC Investigation Policy Exhibit B Level Descriptor and IAP Codes-5-23.16 UHC Adverse Incident Critical Incident Policy and Procedure_revised 10.2016rev. (2) LA_Acute_Care_Manual	Full	Requirement addressed as cited for 8.12.1.	
8.12.3	The MCO shall submit individual PCP and specialized behavioral health provider profile reports to DHH quarterly. MCO provider profiling activities shall include, but are not limited to, the following:	Email Confirmation of Discontinued Reporting	Full	Requirement addressed by: Email Confirmation of Discontinued Reporting – Report 072 PCP Profile, July 13, 2015	
8.12.3.1	Utilization of out-of-network providers – The MCO shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	Email Confirmation of Discontinued Reporting	Full	Requirement addressed as cited for 8.12.3.	
8.12.3.2	Specialist referrals – The MCO shall maintain a procedure to identify and evaluate member specialty provider referral	Email Confirmation of Discontinued Reporting	Full	Requirement addressed as cited for 8.12.3.	

Utilization Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	utilization by its PCP panel;				
8.12.3.3	Emergency department utilization – The MCO shall maintain a procedure to identify and evaluate member emergency department referral utilization by its provider panel;	Email Confirmation of Discontinued Reporting	Full	Requirement addressed as cited for 8.12.3.	
8.12.3.4	Hospital admits, lab services, medications, and radiology services – The MCO shall maintain a procedure to identify and evaluate member's utilization; and	Email Confirmation of Discontinued Reporting	Full	Requirement addressed as cited for 8.12.3.	
8.12.3.5	Individual provider clinical quality performance measures as indicated in Appendix J.	Attachment A-5 Final 3.21.16 Attachment E Incentive Based Performance Measures Amd 5 GI.2 Attachment E Incentive Based Performance Measures Amd 5 AppendixJ_PerformanceMeasures[1] Appendix J Performance Measure Reporting Amd 5 Appendix J Amd 1 Final (3) Attachment B Statement of Work Amd 5 Final 3.21.16 2016 updated Final LA Performance Measure Submission guide_8_2	Full	Requirement addressed by: (Physical and behavioral health) Attachment E Incentive Based Performance Measures Amd 5 and Amd 5 GI.2 (Incentivized measures noted) and in Appendix J Performance Measures and Amd 1 Final and Amd 5 Also addressed by: Louisiana Acute Care Provider Manual (p. 67) (Physical and behavioral health) Example 1 – Provider Scorecard	
8.13	**PCP and Behavioral Health Provider Utilization & Quality Profile Reporting Requirements**				
8.13.0	The MCO shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Email Confirmation of Discontinued Reporting	Full	Requirement addressed as cited for 8.12.3.	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11	**Disenrollment**				
11.11.1	Disenrollment is any action taken by DHH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the Bayou Health Program.				
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	2016 Disenrollment	Full	2016 Disenrollment pg 2	
11.11.3	**Member Initiated Disenrollment**				
11.11.3.1	A member may request disenrollment from a MCO as follows: For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member requests to be assigned to the same MCO as family members; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and DHH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; • The member's active specialized behavioral health provider ceases to contract with the MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by DHH and/or its agent.	2016 Disenrollment	Full	Member requests for dis enrollment are directed to the enrollment broker/DHH for approval	

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If DHH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).	2016 Disenrollment	Full	2016 Disenrollment pg 1	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	2016 Disenrollment	Full	2016 Disenrollment pg 1	
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	2016 Disenrollment	Full	2016 Disenrollment pg 1	
11.11.4	**MCO Initiated Disenrollment**				
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).	2016 Disenrollment	Full	2016 Disenrollment pg 3-4	
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary**	2016 Disenrollment	Full	2016 Disenrollment pg 3-4	

Eligibility, Enrollment and Disenrollment					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Member Disenrollment). In accordance with 42 CFR 438.56(b)(3), DHH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.				
11.11.4.3	The following is the only allowable reason for which the MCO may request involuntary disenrollment of a member: the member misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to DHH;	2016 Disenrollment	Full	2016 Disenrollment pg 2 #2	
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	2016 Disenrollment	Full	2016 Disenrollment pg 5, pg 11	
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	2016 Disenrollment	Full	2016 Disenrollment #s 4 and 9	
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	2016 Disenrollment	Full	2016 Disenrollment #5	
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	2016 Disenrollment	Full	2016 Disenrollment #11	
11.11.4.8	The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new MCO.				

Eligibility, Enrollment and Disenrollment					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.				
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	2016 Disenrollment	Full	2016 Disenrollment #7	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**				
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):				
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: Flesch – Kincaid; Fry Readability Index; PROSE The Readability Analyst (software developed by Educational Activities, Inc.); Gunning FOG Index; McLaughlin SMOG Index; or other computer generated readability indices accepted by DHH.	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 10) Sample written materials submitted: Member Handbook for Physical Health Services Member Handbook for Mental Health and Substance Use Treatment Services UHC Newsletter – Fall 2015, Spring 2016 Health and Self-Management Brochure Healthy 1st Steps Brochure UHC Sesame Street We Have the Moves Controlling Asthma Brochure Controlling Diabetes Brochure Heart Smart Sisters Flyer – April-July 2016	
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by DHH.	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Full	Requirement addressed as cited at 12.9.1.	
12.9.3	DHH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Full	Requirement addressed as cited at 12.9.1. MCO personnel provided an example of readability statistics (newsletter).	
12.9.4	If a person making a testimonial or endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 10)	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.9.5	All written materials must be in accordance with the DHH "Person First" Policy, Appendix NN.	UHC Member Education PP - Required Materials Member Handbook for Physical Health Services	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 10) and as cited at 12.9.1.	
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	UHC Member Education PP - Required Materials Member Handbook for Physical Health Services	Full	Requirement addressed as cited at 12.9.1.	
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	UHC Member Education PP - Required Materials **Note:** No sample marketing materials to provide as we do not do multi-page marketing materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 10) The MCO notes no multi-page marketing materials are published.	
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Substantial	Requirement substantially addressed by: UHC Member Education PP - Required Materials (p. 10) Member Handbook for Physical Health Services (p. 12, 49) Member Handbook for Mental Health and Substance Use Treatment Services (p. 13, 32) UHC Member Education PP - Required Materials (p. 13) notes the member is informed of interpretation services available *at no cost* during the Welcome Call. UCSMM 06 11 Accessibility and Initial Response P/P (p. 1) notes interpretation services available at *toll-free* numbers. Recommendation The Member Handbook should also state interpretation services are available at no cost to the member.	UHC: Agree with the recommendation.
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP -	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	Member Handbook for Physical Health Services		Required Materials (p. 10) Member Handbook for Physical Health Services (p. 15) Member Handbook for Mental Health and Substance Use Treatment Services (p. 14)	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These alternatives must be provided at no expense to the member.	UHC Member Education PP - Required Materials UCSMM 03 13 Public Communication and Marketing	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 10) Member Handbook for Physical Health Services (cover page – toll-free TTY number) Member Handbook for Mental Health and Substance Use Treatment Services (cover page – toll-free TTY number)	
12.11	**Member Education – Required Materials and Services**				
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 11)	
12.11.3	**Member Materials and Programs for Current Enrollees**				
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	UHC Community Plan – Healthy Louisiana Site: http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html	Full	Requirement addressed by: UHC Community Plan Healthy Louisiana website http://www.uhccommunityplan.com/la/medicaid/healthy-louisiana.html Member Handbook for Physical Health Services (p. 43) – specific on-line resources/web pages, cell phone options, mobile apps, social media Member Handbook for Behavioral Health Services (p. 9) – on-line resources at https://www.liveandworkwell.com/	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				public/	
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	UHC Newsletter - Fall 2015	Full	Requirement addressed by: UHC Newsletter – Fall 2015, Spring 2016	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Bayou Health Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	EPSDT and Wellness Programs	Full	Requirement addressed by: Health and Self-Management Brochure Healthy 1st Steps Brochure UHC Sesame Street We Have the Moves Heart Smart Sisters Flyer – April-July 2016 EPSDT and Wellness Programs – member and provider handbook sections, newsletter articles, website postings	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Controlling Asthma Brochure	Full	Requirement addressed by: Controlling Asthma Brochure Controlling Diabetes Brochure	
12.11.3.5	Materials focused on health promotion programs available to the members;	UHC Sesame Street We Have the Moves	Full	Requirement addressed as cited at 12.11.3.3.	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Health and Self Management Brochures	Full	Requirement addressed by: Health and Self-Management Brochure UHC Newsletter – Fall 2015, Spring 2016	
12.11.3.7	Materials that promote the availability of health education classes for members;	Heart Smart Sisters Flyer April-July 2016	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 45) Heart Smart Sisters Flyer April-July 2016	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Controlling Diabetes Brochure	Full	Requirement addressed as cited at 12.11.3.4.	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Healthy 1st Steps Brochure	Full	Requirement addressed by: Healthy 1st Steps Brochure EPSDT and Wellness Programs (p. 3, 4, 10)	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
12.11.3.11	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 13)	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 13)	
12.12	**MCO Member Handbook**				
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (f)(6) for each of the covered populations as specified in section 3.3.3.).	Member Handbook for Physical Health Services Member Handbook for Mental Health and Substance Use Treatment	Full	Requirement addressed by: Member Handbook for Physical Health Services Member Handbook for Mental Health and Substance Use Treatment Services	
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:				
12.12.1.2	Table of contents;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p.5) Member Handbook for Mental Health and Substance Use Treatment Services (p.5)	
12.12.1.3	A general description about how MCOs operate, member rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	Member Handbook for Physical Health Services	Full	Requirement addressed in the Member Handbooks: How MCOs operate – Physical Health Services (p. 4, entire document) MH and SU Treatment Services (p. 3, entire document) Rights and Responsibilities – Physical Health Services (p. 53) MH and SU Treatment Services (p. 38) ED for non-emergent conditions – Physical Health Services (p. 25 urgent care, p. 20 nurseline, p. 54 responsibilities and ED use) MH and SU Treatment Services (p. 15 nurseline to help make decision	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				re ED, urgent care, PCP appointment, self-care, p. 39 responsibilities and ED use) PCP selection – Physical Health Services (p. 15) MH and SU Treatment Services (p. 14) PCP role as coordinator – Physical Health Services (p. 15, 21, 29) MH and SU Treatment Services (N/A, p. 21 provider coordinates referrals)	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 59) and Member Handbook for MH and SU Treatment Services (p. 43)	
12.12.1.5	Member's right to change providers within the MCO;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 16) and Member Handbook for MH and SU Treatment Services (p. 14)	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 15) and Member Handbook for MH and SU Treatment Services (p. 14)	
12.12.1.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook for Physical Health Services	Full	Requirement addressed as cited for 12.12.1.3.	
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs, including chronic care management, tobacco cessation, and problem gaming;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 29-47 benefits, p. 45 wellness programs, p. 11 chronic disease management programs) and the Member Handbook for MH and SU Treatment Services (p. 21-30 benefits, p. 20 tobacco cessation, gambling disorders)	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 22 prior	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
				authorizations, p. 28-42 benefits) and the Member Handbook for MH and SU Treatment Services (p. 19 prior authorizations, p. 20-30 benefits)	
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 7) and the Member Handbook for MH and SU Treatment Services (p. 7)	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 33 family planning, p. 21 out of network) and the Member Handbook for MH and SU Treatment Services (p. 18 out of network)	
12.12.1.12	The extent to which, and how, after-hours , crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 21, 25, 26) and the Member Handbook for MH and SU Treatment Services (p. 13, 16,18, 20)	
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 26) and the Member Handbook for MH and SU Treatment Services (p. 20)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook for Physical Health Services Member Handbook for Mental Health and Substance Use Treatment	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 21 referrals, 30 chiropractic , 38 podiatry) and the Member Handbook for MH and SU Treatment Services (p. 21 referrals, p. 21-30 specialized behavioral health services)	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with DHH;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 41-47 value added benefits) and Member Handbook for MH and SU Treatment Services (p. 20 tobacco cessation, gambling)	
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 53) and the Member Handbook for MH and SU Treatment Services (p. 39)	
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook for Physical Health Services	Full	Requirement addressed as cited at 12.12.1.15 and Member Handbook for Physical Health Services (p. 44). For Medicaid services not covered by UHC, call the Louisiana Medicaid Customer Service Unit's toll free number.	
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 55-63) and the Member Handbook for MH and SU Treatment Services (p. 40-47)	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: the right to a hearing; the method for obtaining a hearing; and the rules that govern representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing	Member Handbook for Physical Health Services	Full	Requirement addressed as cited at 12.12.1.18.	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	a grievance or appeal; • The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member; • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.				
12.12.1.20	Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 52) and the UHC Member Education PP - Required Materials (p. 15 changes in la)	
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;			Health Services (p. 50-51) and the Member Handbook for MH and SU Treatment Services (p. 34)	
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 19) and the Member Handbook for MH and SU Treatment Services (p. 17)	
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 11-12 member services phone number, fax number and email address, p. 52, 61 mailing address). It is also addressed in the Member Handbook for MH and SU Treatment Services (p. 13 member services phone number, fax number and email address, 36m 40m 45 mailing address)	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 23-24) and the Member Handbook for MH and SU Treatment Services (p. 16)	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook for Physical Health Services	Full	Requirement addressed in Member Handbook for Physical Health Services pgs 17, and pgs 31-32	
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 54) and the Member Handbook for MH and SU Treatment Services (p. 39)	
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the MCO;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 49-50) and the Member Handbook for MH and SU Treatment Services (p. 33-34)	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 7) and the	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;			Member Handbook for MH and SU Treatment Services (p. 7)	
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	Member Handbook for Physical Health Services	Substantial	Requirement addressed as cited in 12.9.8. Spanish noted in the: Member Handbook for Physical Health Services (p. 12) and the Member Handbook for MH and SU Treatment Services (p. 13) Recommendation Member handbooks should state interpretation services are available at no cost to the member.	UHC: Agree with the recommendation.
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 22) and the Member Handbook for MH and SU Treatment Services (p. 19)	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to DHH and MCO toll-free numbers and website established for that purpose;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 12, 51) and the Member Handbook for MH and SU Treatment Services (p. 35)	
12.12.1.32	Any additional text provided to the MCO by DHH or deemed essential by the MCO;	Member Handbook for Physical Health Services	Full	Requirement Addressed throughout the Document	
12.12.1.33	The date of the last revision;	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 1) and the Member Handbook for MH and SU Treatment Services (p. 1)	
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.6(h)]. Service utilization policies; and How to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 50-51) and the Member Handbook for MH and SU Treatment Services (p. 34-35)	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to:	Member Handbook for Mental Health and Substance	Full	Requirement addressed by: Member Handbook for MH and SU	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	• A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers; • 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; • 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 • 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.	Use Treatment		Treatment Services (p. 21-30 benefits; p. 3, 8-9 resilience and support; p. 50 objection to information sharing). MCO personnel reported no age of consent for minors, and submitted the HIPAA Job Aide in support.	
12.12.1.36	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	UHC Newsletter - Spring 2016	Full	Requirement addressed by: UHC Newsletter - Spring 2016 (p. 4)	
12.12.1.37	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to DHH for approval within four weeks of the annual renewal and upon any changes prior to being made available to members.	Member Handbook for Physical Health Services Member Handbook for Mental Health and Substance Use Treatment	Full	Requirement addressed in Policy 12.12.1.33. Submission to LDH addressed by UHC Member Education PP - Required Materials (p. 15).	
12.14	**Provider Directory for Members**				
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 18)	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	UHC Member Education PP - Required Materials LABH Provider Directory LAACUTE-Provider Directory C_S Provider Directory	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 18) C_S Provider Directory Creation Policy LAACUTE-Provider Directory – file damaged LABH Provider Directory	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Creation Policy			
12.14.1.2	Web-based, searchable, online directory for members and the public;	Covered – existing at: http://www.americhoice.com /find_doctor/first.jsp?xplan=uhcla&xtitle=Doctor www.liveandworkwell.com	Full	Requirement addressed by: http://www.americhoice.com/find_doctor/first.jsp?xplan=uhcla&xtitle=Doctor#find a provider (or select Doctor Lookup from main page) and www.liveandworkwell.com (select Find a Provider from main page)	
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI or other designee as determined by DHH; for the Enrollment Broker; and	LAACUTE-Provider Directory	Full	Requirement addressed by: C_S Provider Directory Creation Policy	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 18)	
12.14.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by DHH.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 18)	
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:				
12.14.4.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, behavioral health and other specialists, and hospitals at a minimum, that are not accepting new patients;	LAACUTE-Provider Directory Names, locations, telephone numbers of, and non-English languages spoken Identification of Providers. PCPs, Specialists, and Hospitals	Full	Requirement addressed as cited at 12.12.1.33 and: UHC Member Education PP - Required Materials (p. 18-19) C_S Provider Directory Creation Policy (embedded document – data dictionary) LAACUTE-Provider Directory LABH Provider Directory (p. 4 description of listings)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		www.liveandworkwell.com		and websites as cited at 12.14.1.2.	
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	LAACUTE-Provider Directory ID of PCP ID of Specialists ID of Hospitals PCP groups Clinics Behavioral Health Providers Behavioral Health Facilities FQHCs/RHCs www.liveandworkwell.com	Full	Requirement addressed as cited at 12.14.4.1. LAACUTE-Provider Directory LABH Provider Directory And websites as cited at 12.14.1.2. The websites allow search by specialization or facility type. MCO personnel demonstrated use of the provider directory website to select services for certain age-groups (0-5, 6-12, 13-18 years) and residential facilities for children and adolescents.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 18-19) and Member Handbook for Physical Health Services (no restrictions – p. 9 and throughout) Member Handbook for MH and SU Treatment Services (no restrictions – p. 14)	
12.14.4.4	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).	UHC Member Education PP - Required Materials www.liveandworkwell.com	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 19) and websites as cited at 12.14.1.2 and 12.14.4.1. The websites give hours of operation.	
12.17.15	**Members' Rights and Responsibilities**				
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	Member Handbook for Physical Health Services	Full	Requirement addressed as cited at 12.12.1.3 and: LA Acute Care Manual – Provider Manual as submitted for the UM compliance review (p. 21).	
12.15.2	Members Rights. The rights afforded to	Member Handbook for	Full	Requirement addressed as cited	

Marketing/Member Education					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	current members are detailed in Appendix AA, Members' Bill of Rights.	Physical Health Services		immediately above.	
12.17.16	**Member Responsibilities**				
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 54) Member Handbook for MH and SU Treatment Services (p. 39)	
12.17.16.2	The MCO members' responsibilities shall include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up	Member Handbook for Physical Health Services	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 54, grievances p. 55) Member Handbook for MH and SU Treatment Services (p. 39, grievances p. 40)	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.				
12.18	**Notice to Members of Provider Termination**				
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 22)	
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	UHC Member Education PP - Required Materials	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 22)	
12.19	**Oral and Written Interpretation Services**				
12.19.1	In accordance with 42 CFR §438.10(b)(1) DHH shall provide on its website the prevalent non-English language spoken by enrollees in the state.				
12.19.2	The MCO must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is	Language Line SOP UCSMM 06 11 Accessibility and Initial Response	Full	Requirement addressed as cited at Addressed as cited at 12.9.8 and 12.12.1.29 and: UCSMM 06 11 Accessibility and Initial Response Language Line SOP	

Marketing/Member Education					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and how to access those services. On materials where this information is provided, the notation should be written in Spanish.				
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	Language Line SOP UCSMM 06 11 Accessibility and Initial Response	Full	Requirement addressed by: UHC Member Education PP - Required Materials (p. 23)	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.0	**Member Grievance and Appeals Procedures**				
13.2	**General Grievance System Requirements**				
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found in the Member Handbook on pages 55-61, and in the Grievance System Process POL 2015-01 and the Appeals Process Policy number UHL_12.0 (v2_01232015)	
13.2.2	**Filing Requirements**				
13.2.2.1	**Authority to File**				
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found in the Member Handbook on pages 55-61, and in the Grievance System Process POL 2015-01 and the Appeals Process Policy number UHL_12.0 (v2_01232015)	
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found in the Member Handbook on pages 55-61, and in the Grievance System Process POL 2015-01 and the Appeals Process Policy number UHL_12.0 (v2_01232015)	
13.2.3	**Time Limits for Filing** The member must be allowed thirty (30) calendar days from the date on the MCO's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf and with the member's written consent may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	LA_Handbook_EN UCSMM 07 11 Appeal Review Timeframes	Substantial	On-site: Evidence in support of this requirement was found on Page 56 of the Member Handbook; however, this requirement is not addressed in the Grievance POL 2015-01. In the Appeals Process Policy UHL_12.0, this is addressed with regard to the timeframe between an appeal determination and State Fair Hearing request, but does not with regard to 30 days	Plan's response post-onsite: The plan will revise its Grievance System policy to reflect the current Louisiana contractual requirement of 30 calendar days. The plan is also revising its policy to clarify references to appeal process and for grievances UHC: Agree with the recommendation.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				from MCO action or grievance event to grievance or appeal filing. Recommendation: The plan should address the requirement to allow the member 30 days from MCO action or grievance event to grievance or appeal filing in a single revised policy document that addresses both appeals and grievances, as there are inconsistencies (both overlaps and gaps) between what is noted as the appeals policy and what is noted as the grievance policy and, consequently, the policy is not clearly communicated. Or the plan may elect to reconcile theses inconsistencies by retaining separate appeals and grievance policies. Global Recommendation: It is also a general recommendation that either a single Grievance and Appeals policy or separate Grievance and Appeals policies be developed in order to comprehensively address and clearly convey the contract requirements (including those listed in UCSMM 07 12 Appeal Process and Record Documentation.pdf) without duplication. Policies should be named appropriately so that it is clear whether it they apply to appeals, only, grievance, only, or both.	
13.2.4 13.2.4.1	**Procedures for Filing** The member or provider may file an appeal either orally or in writing.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01	Full	Evidence in support of this requirement was found on Page 56 of the Member Handbook and in	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation		the Appeal Process and Requirement Policy UHL_12.0.	
13.2.4.2	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and must be provided upon request of the member. The MCO shall make all forms easily available on the MCO's website.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN	Full	Evidence in support of this requirement was found on Pages 58 and 61 of the Member Handbook, as well as in the Acknowledgement Letter template.	
13.3	**Grievance/Appeal Records and Report**				
13.3.1	The MCO must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 8 of the Grievance policy POL 2015-01 with regard to both grievances and appeals, as well as on page 4 of the document UCSMM 07 12 Appeal Process and Record Documentation.	
13.3.2	The MCO shall electronically provide DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015)	Full	Evidence in support of this requirement for both grievances and appeals was found on Page 8 of the Grievance POL 2015-01.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
13.3.3	The MCO will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	LA Inquiries Grievances and State Fair Hearings LA Grievance Coordinator (SFH) - SOP (update August 2016)	Substantial	POL 2015-01 grievance Process addresses this requirement generally by stating that the plan is required to submit information regarding appeal and grievance activity as directed by DHH, but does not specifically address **prompt forwarding of adverse decisions** to DHH upon DHH or **member** request. Recommendation: The plan should address this requirement in a policy that addresses both appeals and grievances.	Plan post-onsite response: The plan will update the policy to make clearer that it shall promptly forward adverse decisions to LDH upon request by the LDH or member. UHC: Agree with the recommendation.
13.4	**Handling of Grievances and Appeals**				
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:				
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) 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 monthly grievance log;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) Acknowledgement Letter template UCSMM 07 11 Appeal Review Timeframes	Substantial	Grievance POL 2015-01, Page 3, addresses that acknowledgement letters "will be sent upon receipt of the appeal", but does not address the 5 day timeframe nor address grievances. On page 4, POL 2015-01 addresses sending written acknowledgement of an appeal within 3 working days of receipt if appeal is submitted in writing, but again, does not address acknowledgement of grievances. POL 2015-01 generally addresses the requirement for logging appeals and grievances, but does not specifically address the requirement to report in the monthly grievance log those grievances resolved same day. File Review Findings: 3 of 15 files were not compliant with this requirement.	UHC: Agree with the recommendation.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				Recommendation: The plan should revise the relevant policies and procedures to address these requirements.	
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 49 of the Member Handbook and on Page 4 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.4.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 13 Appeal Notices	Minimal	The requirement that individuals deciding appeals not be involved in previous reviews/decisions was met on Page 3 of Grievance POL 2015-01; the requirement that appeals regarding medical necessity or clinical issues be reviewed/decided by a health care professional with appropriate clinical expertise was met on Pages 4-5 of POL 2015-01; however, although this document is described as pertaining to Member Grievances, evidence was not found to support these requirements with respect to grievances. File Review Findings: None of the 5 applicable files were compliant with this requirement. Recommendation: The plan should address this requirement for both appeals and grievances in the appropriate policy(s).	Plan's post-onsite response: The plan will update its Grievance System policy to clarify. UHC: Agree with the recommendation.
13.4.2	**Special Requirements for Appeals** The process for appeals must:				
13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01	Full	Page 57 of the Member Handbook addresses this requirement by instructing the member or provider	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.	Effective February 1, 2015) LA_Handbook_EN UCSMM 07 12 Appeal Process and Record Documentation		to call Member Services for an expedited review of an Action if the member or their provider want a fast decision because the member's health is at risk. Grievance POL 2015-01 addresses the requirement that an expedited appeal may be filed orally without additional enrollee follow-up required.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this in the case of expedited resolution).	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	The requirement to provide the member with the opportunity to present evidence in person/writing is met on page 5 of UCSMM 07 12 Appeal Process and Record Documentation. The requirement that the MCO informs the member of the limited time for expedited resolution of appeals is met in Grievance POL 2015-01.	
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found in UCSMM 07 12 Appeal Process and Record Documentation on Page 5.	
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found in UCSMM 07 12 Appeal Process and Record Documentation on Page 5.	
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	CS - LA Appeals and Grievances Bulletin LA Inquiries Grievances and State Fair Hearings	Full	MCO Staff educational materials were provided, i.e., LA Appeals and Grievances Bulletin and LA Inquiries Grievances and State Fair Hearings. Post- onsite, the plan provided employee training agenda, power point presentation and attendance sheet.	
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the	Chief Medical Officer job description	Substantial	The Chief Medical Officer job description was cited by the plan as	UHC: Agree with the recommendation.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Dr. Ann Kay Logarbo, Medical Director/Chief Medical Officer		evidence in support of this requirement; however, this document did not contain language regarding appeals and grievances. Post onsite, the plan provided POL 2015-01 which did include language that met this requirement. File Review Findings: 1 of 5 applicable cases met this requirement.	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified in §13.6 of this RFP, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on pages 5-7 of Grievance POL 2015-01.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 13 Appeal Notices	Full	Evidence in support of this requirement was found in the Member Handbook on pages 58-59 and 61.	
13.5	**Notice of Action**				
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10(c) and (d) and Section 12 of this RFP to ensure ease of understanding.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on pages 4-5.	
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:				
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015)	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 4.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		UHL_12_Appeals Process and Requirements v2_01232015 UCSMM 06 18 Initial Adverse Determination Notice			
13.5.2.2	The reasons for the action;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 4.	
13.5.2.3	The member's right to file an appeal with the MCO;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 4.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 4.	
13.5.2.5	The procedures for exercising the rights specified in this section;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 5.	
13.5.2.6	The circumstances under which expedited resolution is available and how to request it;	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 5.	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal,	UnitedHealthcare Community Plan Louisiana Grievance	Full	Evidence in support of this requirement was found in UCSMM	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 06 18 Initial Adverse Determination Notice		06 18 Initial Adverse Determination Notice on page 5.	
13.5.2.8	Oral interpretation is available for all languages and how to access it.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 18 Initial Adverse Determination Notice	Full	Evidence in support of this requirement was found in UCSMM 06 18 Initial Adverse Determination Notice on page 5.	
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:				
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action, except:	BayouHealthStateFairHearing CompanionGuideFinal2015 UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on page 7 of UCSMM 06 16 Initial Review Timeframes.	
13.5.3.1.1	The period of advanced notice is shortened to five (5) days if probable member fraud has been verified or by the date of action for the following: • In the death of a recipient; • A signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information); • The recipient's admission to an institution where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or	BayouHealthStateFairHearing CompanionGuideFinal2015 UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on page 7 of UCSMM 06 16 Initial Review Timeframes.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	• As otherwise permitted under 42 CFR §431.213.				
13.5.3.2	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	BayouHealthStateFairHearing CompanionGuideFinal2015	Full	Post on-site document, "State Fair Hearing Companion Guide" provided evidence to support this requirement.	
13.5.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on Pages 7-8 of UCSMM 06 16.	
13.5.3.4	If the MCO extends the timeframe in accordance with above, it must: • Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on Page 8 of UCSMM 06 16.	
13.5.3.5	On the date the timeframe for service authorization as specified in § 13.5.3.3 expires. Untimely service authorizations constitute a denial and are thus adverse actions.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on Page 8 of UCSMM 06 16.	
13.5.3.6	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015)	Full	Evidence in support of this requirement was found on Page 8 of UCSMM 06 16.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	LA_Handbook_EN UCSMM 06 16 Initial Review Timeframes			
13.5.3.7	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 06 16 Initial Review Timeframes	Full	Evidence in support of this requirement was found on Page 8 of UCSMM 06 16.	
13.5.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.				
13.6	**Resolution and Notification**				
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this overall requirement was found in the below documents regarding each component requirement.	
13.6.1	**Specific Timeframes**				
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this requirement was found on page 7 of Grievance POL 2015-01.	
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this requirement was found on page 6 of Grievance POL 2015-01.	
13.6.1.3	**Expedited Resolution of Appeals**	UnitedHealthcare Community	Full	Evidence in support of this	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 11 Appeal Review Timeframes		requirement was found on page 6 of Grievance POL 2015-01.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) Extension Letter template UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this requirement was found on page 6 of Grievance POL 2015-01.	
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on page 6 of Grievance POL 2015-01.	
13.6.3 13.6.3.1 13.6.3.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 13 Appeal Notices	Full	Evidence of the requirement for the MCO to provide written notice to the member of the disposition of a grievance was met on page 1 of Appeal Process and Requirements UHL_12.0. Evidence in support of the requirement regarding expedited resolution was found on page 5 of Grievance POL 2015-01.	
13.6.4 13.6.4.1 13.6.4.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 13 Appeal Notices	Substantial	Evidence of most of these requirements was found on Page 7 of Grievance POL 2015-01; however, the date of the resolution was not included in the list of elements in the notice of appeal resolution letter. Plan's response: The plan will update its Grievance System policy (POL 2015-1). However, the appeal	UHC: Agree with the recommendation.

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.			determination letter template does include verbiage to enter the date of the resolution. File Review Findings: 4 of 15 files were not compliant with the requirement to include the results of the resolution process. 6 of the 15 files were not written in an easily understandable manner.	
13.6.5	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.				
13.6.5.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the MCO's notice of resolution.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this requirement was found on Page 3 of UCSMM 07 11 Appeal Review Timeframes, and on Page 58 of the Member Handbook.	
13.6.5.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) LA_Handbook_EN	Full	Evidence in support of this requirement was found on Page 1 of Grievance POL 2015-01 and on page 58 of the Member Handbook.	
13.7	**Expedited Resolution of Appeals**				
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, 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 or health or ability to attain, maintain, or regain maximum function.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 8 of UHL_12_Appeals Process and Requirements v2_01232015.	
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015)	Full	Evidence in support of this requirement was found on Page 5 of UCSMM 07 12 Appeal Process and Record Documentation.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	written consent, who requests an expedited resolution or supports a member's appeal.	UCSMM 07 12 Appeal Process and Record Documentation			
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) Urgent Downgrade Ack Ltr template UCSMM 07 11 Appeal Review Timeframes	Substantial	Evidence of the requirement to transfer the appeal to the standard resolution time frame was found on Page 5 of Grievance POL 2015-01. However, the Urgent Downgrade Ack Ltr template address the member's right to file a grievance or that this does not constitute an Action. Plan Response post-onsite: The Plan will update the policy to clarify that the denial of a member's request for expedited resolution does not constitute n Action by the Plan. The plan also will update its Urgent Downgrade Acknowledgement letter template to inform the member of the right to file a grievance of the denial of the request for expedited resolution, and that the denial does not constitute an Action by the plan.	UHC: Agree with the recommendation.
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence of this requirement was found on Page 5 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	No additional follow-up may be required.				
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.8	**Continuation of Benefits**				
13.8.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.				
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: • The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and • The member requests extension of	BayouHealthStateFairHearing CompanionGuideFinal2015 UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of these requirements was found on Page 4 of UCSMM 07 11 Appeal Review Timeframes.	

Member Grievances and Appeals					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	benefits.				
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	BayouHealthStateFairHearing CompanionGuideFinal2015 UCSMM 07 11 Appeal Review Timeframes	Full	Evidence in support of these requirements was found on Page 5 of UCSMM 07 11 Appeal Review Timeframes.	
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	BayouHealthStateFairHearing CompanionGuideFinal2015 UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.9	**Information to Providers and Contractors**				
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g)(1) about the grievance system to all providers and contractors at the time they enter into a contract.	13.9.0 2016 Provider Manual	Full	Evidence in support of this requirement was found on Page 92 of the Provider Manual. Post onsite, the plan provided the Medical Subcontractor contract which did address this requirement.	
13.10	**Recordkeeping and Reporting Requirements**				
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the prior written approval of DHH.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015)	Full	Evidence in support of this requirement was found on Page 8 of Grievance POL 2015-01.	

Member Grievances and Appeals					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
13.11	**Effectuation of Reversed Appeal Resolutions**				
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	UnitedHealthcare Community Plan Louisiana Grievance System Process (POL 2015-01 Effective February 1, 2015) UCSMM 07 12 Appeal Process and Record Documentation	Full	Evidence in support of this requirement was found on Page 6 of UCSMM 07 12 Appeal Process and Record Documentation.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**				
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.240(a)(1), to:				
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QIPD 2016 C_S _LA_FINAL_EQRO UHC 121 QI Work Plan 2016_FINAL_EQRO	Full	Pages 6 and 7 of the QIPD 2016 C_S_LA_FINAL_EQRO provides evidence in support of this requirement, with responsible staff positions indicated for specific activities in the UHC 121 QI Work Plan 2016.	
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QIPD 2016 C_S _LA_FINAL_EQRO UHC 121 QI Work Plan 2016_FINAL_EQRO	Full	As above.	
14.1.4	Detect and address underutilization and overutilization of services	QIPD 2016 C_S _LA_FINAL_EQRO POL.2413020	Full	This requirement is addressed in the policy document POL.2413020 and on page 23 of the QIPD 2016 C_S_LA_FINAL_EQRO document.	
14.1.5	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by DHH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	POL.2413020	Full	POL.2413020 addresses this requirement by identification of 3 HEDIS measures, with one each for appropriateness of testing, medication and treatment for the Quality Management Provider Profile. On-site, the plan provided evidence of 3 medically indicated procedures for prior authorization: X-rays, pharmacy step therapy and DME.	
14.1.6	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for	ADHD_PIP_LA_Quality_UHC1 01316 (2) Bayou Health Plan UHC Prematurity PIP Final_822016	Full	The UHC Prematurity PIP provides evidence in support of this requirement.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	ADHD and other disorders for children under age 6.				
14.1.7	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	ADHD_PIP_LA_Quality_UHC1 01316 (2) POL.2413020	Full	The UHC ADHD PIP documents and POL.2413020 provide evidence in support of this requirement.	
14.1.8.	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QIPD 2016 C_S _LA_FINAL_EQRO	Minimal	Page 9 of the QIPD 2016 document addresses this requirement specifically for members with complex health, i.e., high-cost, complex, at risk individuals including those with physical and developmental disabilities as well as those with chronic health needs. On-site, the plan discussed how the plan addresses needs of the following subpopulations with special health care needs: Pediatric Day Health Care receive specialized CM services; Members needing private duty health care services; and members on ventilation assisted care who receive home visits. Case Management File Review Findings 3 of 10 case management files did not have a diagnosis documented. 9 of 10 case management files did not have documentation that an individual needs assessment and diagnostic assessment was conducted. 7 of 10 case management files did not have evidence of a care plan. 5 of 9 applicable files lacked evidence of involvement of member/family in treatment care planning, and 6 of 9 applicable files lacked evidence of revision of treatment plan as needed. 7 of 10 files lacked evidence of short and long term treatment objectives.	UHC: Agree with the recommendation.

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				8 of 10 files lacked evidence of a plan of care for members with Special Health Care Needs. 5 of 10 files lacked evidence of coordination of activities with the Chronic Care Management Program. 9 of 10 files did include evidence of care coordination and monitoring of outcomes.	
14.1.9	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 31 of the QIPD 2016 document.	
14.1.10	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of DHH.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on Pages 7 and 8 of the QIPD 2016 document.	
14.1.11	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found throughout the QID 2016 document.	
14.1.12	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found throughout the QID 2016 document.	
14.1.14	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on pages 9 and 10 of the QIPD 2016 document.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.				
14.1.15	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Minutes_MAC_3rd_Quarter_Sept_13_2016 Approved Minutes_MAC_4th Quarter_Dec_15_2015 Approved QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in the Minutes_MAC_4th_2016, which documented 2 members in MAC attendance, with processes in place described on pages 10-11 of the QIPD 2016 document.	
14.1.16	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to DHH and other key stakeholders as directed by DHH.	QIPD 2016 C_S _LA_FINAL_EQRO PQ121_QAPI_Program_Description-and-Work_Plan_Cover Letter_2016 EQRO 2015 QI Evaluation_LA_Final_ Approved_03242016_NCQA	Full	Evidence in support of this requirement was found in the PQ121_QAPI_Description-and-Work_Plan_Cover Letter_2016, as well as in the PIP submissions to IPRO.	
14.1.17	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	ADHD_Toolkit Disease_Specific_Guidelines_ Grid Agenda_PAC_2015_07 Minutes_PAC_07192016 2016 Clinical Practice Guidelines_FINAL CPG Provider Portal	Full	Evidence in support of this requirement was found in the ADHD_Toolkit, 2016 Clinical Practice Guidelines_FINAL, and Minutes_PAC_07192016, as well as plan participation in the Collaborative ADHD PIP development process.	
14.1.18	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	QOC Investigation IAP and Disciplinary Action Policy (5-23-16) QOC Investigation Policy Exhibit B Level Descriptor and IAP Codes-5-23.16 2016 QOC PAC Report - CnS	Full	Evidence in support of this requirement was found in the QOC Investigation IAP and Disciplinary Action Policy, 2016 QOC Semi Annual Eval, and 2016 QOC PAC Report.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		LA (Q1 Q2-16) 2016 QOC Semi Annual Eval - CnS LA PAC (Q1 Q2-16) QOC Investigation Policy - Exhibit A - LA Medicaid Regulatory Requirements (10-17-16) (2)			
14.1.19	The MCO shall participate in the DHH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by DHH.	Bayou Health Quality Committee Agenda 3 11 16 Bayou Health Quality Committee Agenda 9.11.15 Medicaid Medical Director Meeting 102716 Minutes_ADHD_and_ Premature Births PIP Meeting July21_2016draft8.15.16 (2) (2)	Full	Evidence in support of this requirement was found in the Minutes ADHD_and_Premature Births PIP Meeting minutes and in the Medicaid Medical Director Meeting minutes 10/27/16.	
14.1.20 14.1.20.1 14.1.20.2	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	318 Utilization of HCBS report_2016 Q2 320 Behavioral Health Treatment Outcomes_2016 Q2	Full	Evidence in support of this requirement was found in the 318 Utilization of HCBS report and in the 320 Behavioral Health Treatment Outcomes 2016 report. On-site, the plan showed the State 320 Report-FFT, MST and Homebuilder.	
	For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to DHH-OBH on an annual base.	320 Behavioral Health Treatment Outcomes_2016 Q2 Provider Express information on Clinical Tools and Quality Initiatives: https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/clinical-tools-and-quality-initiatives.html	Full	Evidence in support of this requirement was found in the 320 Behavioral Health Treatment Outcomes_2016_Q2 document. In addition, the "providerexpress.com" link provides evidence that a strategy is in place to educate providers about CPGs. On site, the plan explained that Report 333, which addresses BH outcome measurement, is due January 2017.	
14.2	**QAPI Committee**				
14.2.1	The MCO shall form a QAPI Committee that				

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	shall, at a minimum include:				
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in Page 21 of the QIPD 2016 C_S_LA_FINAL document.	
14.2.1.2	The MCO Behavioral Health Director;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in Page 21 of the QIPD 2016 C_S_LA_FINAL document.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in Page 21 of the QIPD 2016 C_S_LA_FINAL document.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document. Post on-site, the plan provided QAPI minutes; however, no evidence that a member advocate representative was included on the QAPI committee was found. The MCO disagreed with the recommendation, indicating that the contract states "encourage" but not required. In addition the LA Health Plan has the Member Advisory Committee which addresses member input into the plan. Determination changed from "Substantial" to "Full"	UHC: Disagree with recommendation. The contract states "encourage" but not required. In addition, the LA Health Plan has the member Advisory Committee which addresses member input into the plan.
14.2.1.5	The MCO shall include DHH representative(s) on the QAPI Committee, as designated by DHH as non-voting member(s).	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document. Post on-site, the plan provided April 15, 2016 QMC minutes that documented DHH attendance.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document and in the UHC 121 QI Work Plan 2016.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document and in	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				the UHC 121 QI Work Plan 2016.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 20 of the QIPD 2016 document.	
14.2.2.3	Review and suggest new and or improved QI activities;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in the "Goals" tab of the UHC 121 QI Work Plan 2016.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document.	
14.2.2.5	Designate evaluation and study design procedures;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on pages 21 and 33 of the QIPD 2016 document.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 34 of the QIPD 2016 document, and in the Provider Scorecard.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 22 of the QIPD 2016 document.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 24 of the QIPD 2016 document and, although PAC and MAC minutes also provided supporting documentation. Post-onsite, the plan provided documentation of QAPI/QMC meeting minutes, with attestation regarding DHH document submission.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management services;	QIPD 2016 C_S _LA_FINAL_EQRO 2015 QI Evaluation_LA_Final_ Approved_03242016_NCQA	Full	The plan provided the 2015 QI Evaluation_LA_Final_Approved_032 42016_NCQA report that comprehensively documents the prior year's QAPI program activities. Post on-site, the planer, the plan provided a screenshot that documented upload of the UHC 2015 Annual evaluation to the IPRO ftp site for submission to DHH.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
14.2.2.11	Ensure that the QAPI committee chair attends DHH quality meetings; and	QIPD 2016 C_S _LA_FINAL_EQRO Minutes_ADHD_and_ Premature Births PIP Meeting July21_2016draft8.15.16 (2) (2) Medicaid Medical Director Meeting 102716	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document, as well as in the Medicaid Medical Director Meeting 102716 Agenda, and in the Minutes_ADHD_and_Premature births PIP Meeting July 21_2016.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 28 of the QIPD 2016 document.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	127 QAPI Performance Measures Annual Report-Received PQ121_QAPI_Program_Description-and-Work_Plan_Cover Letter_2016 EQRO QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in Work_Plan_Cover Letter_2016 EQRO.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in the Work_Plan_Cover Letter_2016 EQRO, as well as on page 35 of the QIPD 2016.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 7 of the QIPD 2016 document.	
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 26 of the QIPD 2016 document.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 21 of the QIPD 2016 document.	
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 37 of the QIPD 2016 document.	
14.2.3.6	Describe the methods for ensuring data	QIPD 2016 C_S	Full	The plan reported Prematurity PIP	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	collected and reported to DHH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	_LA_FINAL_EQRO		performance indicators that reflect adherence to clinical practice guidelines, and Page 8 of the QIPD 2016 indicates that "the quality indicators are based on research and use current accepted data collection and analytical methodologies."	
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	UHCCP-LAAuditProcessPolicy UHCCP - LA ACT Fidelity Monitoring Workflow Bayou ACT Fidelity Monitoring Tool 2016 UHCCP_LA Organizational Provider Site 2016 UHCCP-LA Treatment Record Tool 2016	Full	The policy, "Louisiana Medicaid Provider Site and Desktop Audits" describes the process for monitoring the quality of the provider network; the UHCCP- LA ACT Fidelity Monitoring Workflow documents the provider audit process for Site Reviews and Desk Reviews; and the UHCP-LA Treatment Record Tool 2016 documents a template for collecting treatment record audit data.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Results of the evaluation of the impact and effectiveness of the QAPI program.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found on page 35 of the QIPD 2016 document.	
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports for special populations (e.g., DCFS/OJJ, nursing home populations), to DHH using the specifications and format approved by DHH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and DHH.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement is provided by plan submission of PIP documents that address specific subpopulations and Performance Measure reporting for the general and subpopulation membership.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the *MCO Quality Companion Guide and the Behavioral Health Companion Guide.*	audit-11453 audit-11453-HEDIS 11453_Attestation_636010653798974942_HEDIS HEDIS 2016 Workbook	Full	Evidence in support of this requirement is provided by plan submission of the HEDIS 2016 workbook and CAHPS reports.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.2	The MCO is required to report on Performance Measures listed in Appendix J and Reporting Companion Guide which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, CMS Children's Health Insurance Program Reauthorization ACT (CHIPRA) Children's Core Quality Measures, CMS Adult Core Quality Measures, and/or other measures as determined by DHH.	audit-11453 audit-11453-HEDIS 11453_Attestation_636010653798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2	Full	Evidence in support of this requirement is provided by plan submission of the HEDIS 2016 workbook and CAHPS reports.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.3	The MCO shall have processes in place to monitor and self-report all performance measures.	audit-11453 audit-11453-HEDIS 11453_Attestation_636010653798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the audit review table 11453.	
14.2.5.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	audit-11453 audit-11453-HEDIS 11453_Attestation_636010653798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453	Full	Evidence in support of this requirement was found in the 11453 Attestation document.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.5	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	audit-11453 audit-11453-HEDIS 11453_Attestation_636010653798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child	Full	As indicated above, the evidence supports annual PM submission. Evidence was provided to support semi-annual evaluation of Quality of Care and service complaints and referrals for 2016. On-site, the plan explained that templates were under development until September of this year, so there was not opportunity to conduct semi-annual PM submissions. Post on-site, dates of additional quality indicator/improvement submissions on March 20, June 30, November 5 and September 27, 2016 were also provided.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	audit-11453 audit-11453-HEDIS 11453_Attestation_63601065 3798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCom munityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcar e Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcar e Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the HEDIS audit document 11453, with some rates greater than 90% (e.g., childhood IPV and MMR vaccination) but other rates with less than 50% compliance (e.g., 75% medication compliance for people with asthma, Blood Pressure control). The vendor Silverlinks connects members with care gaps to their doctors.	
14.2.5.7	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	Evidence in support of this requirement was found in the QIPD 2016 document, as well as the HEDIS audit tool and the requested Prematurity PIP and ADHD PIP data reporting tools.	
14.2.5.8	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by DHH.	QIPD 2016 C_S _LA_FINAL_EQRO	Full	The plan has met the changing PIP reporting requirements.	
14.2.5.9 14.2.5.9.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Appendix J annotated with "$$."	audit-11453 audit-11453-HEDIS 11453_Attestation_63601065	Full	Evidence in support of this requirement was found in the audit-11453 document (e.g., AWC, ADHD, PPC and FUH).	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		3798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.9.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below DHH's established benchmarks for improvement.				
14.2.5.10	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide six (6) months' notice of such change.	audit-11453 audit-11453-HEDIS 11453_Attestation_63601065 3798974942_HEDIS HEDIS 2016 Workbook HEDIS workbook-11453 HEDIS 2016workbook-11453 12430_UnitedHealthcareCom	Full	As above.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
		munityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)			
14.2.5.11 14.2.5.11.1	**Performance Measures Reporting** All measures contained in Appendix J MCO Performance Measures and the Behavioral Health Companion Guide are reporting measures.				
	14.2.5.11.4 The MCO shall report on performance measures in accordance with the current specifications developed by the measure steward and/or approved by DHH. 14.2.5.11.5 The MCO shall utilize the file naming convention established by DHH for all specialized behavioral health report submissions and re- submissions. 14.2.5.11.6 The MCO shall maintain data integrity, accuracy, and consistency in data. As such, all reports submitted to DHH shall include analytical methodology (e.g., numerator, denominator, sampling methodology, data source, data validation methods, results summary, and source code in a statistical language matching one used by DHH). DHH holds the right to validate all reporting for specialized behavioral health measure performance monitoring.	2016 updated Final LA Performance Measure Submission guide_8_2 InternalReportSpecSignoff LA PTB Measure v2 2016 Initiation of Progesterone Measure 20160627 HEDIS_Final Audit Statement	Full	Evidence in support of this requirement was found in the Internal Report SpecSignoff LA PTB Measurev2 and the HEDIS Final Audit Statement.	
14.2.5.12	**Performance Measure Goals** 14.2.5.12.1 The Department will establish benchmarks for IB Performance measures utilizing the prior year statewide data for the	2016 updated Final LA Performance Measure Submission guide_8_2	Full	Evidence in support of this requirement was found in the 2016 updated Final LA Performance Measure Submission guide_8_2, as	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Bayou Health population.	Medicaid Medical Director Meeting 102716		well as in the baseline Prematurity PIP.	
14.2.5.12.3	DHH shall have the authority to establish final performance measure goals after consultation with the Bayou Health Quality Committee. Final determination of goals is at the sole discretion and approval of DHH	2016 updated Final LA Performance Measure Submission guide_8_2 NQM-025 Rider Audit Tool	N/A	DLH responsibility	
14.2.5.13	**Performance Measure Reporting** 14.2.5.13.1 The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring. 14.2.5.13.2 The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH. **Reporting Measures.** 14.2.5.13.4 The MCO shall provide individual PCP clinical quality profile reports as indicated in Section 8.7 PCP Utilization and Quality Reporting.	2016 updated Final LA Performance Measure Submission guide_8_2 Scorecard Gap Report Provider Score Card	Full	Evidence in support of this requirement was found in the 2016 updated Final LA Performance Measure Submission guide_8_2, the audit-11453 document, the Scorecard Gap Report, and the Provider Score Card.	
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.240.	Appendix DD Amd 1 Final Bayou Health Plan UHC Prematurity PIP Final_822016 Reducing Prematurity PIP Update 2016 updated Final LA Performance Measure Submission guide_8_2 ADHD_PIP_LA_Quality_UHC101316 (2)	Full	Evidence in support of this requirement was found in the Bayou Health Plan UHC Prematurity PIP Final 822016.	
14.2.8.2	The MCO shall perform two (2) DHH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. DHH may require up to two (2) additional projects	Appendix DD Amd 1 Final Bayou Health Plan UHC Prematurity PIP Final_822016	Full	Evidence in support of this requirement was found in the Bayou Health Plan UHC Prematurity PIP Final 822016 and the ADHD_PIP_LA_Quality_UHC101316	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	for a maximum of four (4) projects.	Reducing Prematurity PIP Update 2016 updated Final LA Performance Measure Submission guide_8_2 ADHD_PIP_LA_Quality_UHC101316 (2)		document.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional DHH-approved behavioral-health PIP each contract year.	FUH PIP proposed	Full	Evidence in support of this requirement was found in the ADHD PIP LA Quality UHC101316 document.	
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective quality indicators; • Implementation of system interventions to achieve improvement in quality; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	Bayou Health Plan UHC Prematurity PIP Final_822016 Reducing Prematurity PIP Update 2016 updated Final LA Performance Measure Submission guide_8_2 ADHD_PIP_LA_Quality_UHC101316 (2)	Full	Evidence in support of this requirement was found in the Bayou Health Plan UHC Prematurity PIP Final 822016 and the ADHD_PIP_LA_Quality_UHC101316 document.	
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to DHH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, as well as its relevance to the MCO members and providers; • The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology;	Attachment B Statement of Work Amd 5 Final 3.21.16 Bayou Health Plan UHC Prematurity PIP Final_822016 Reducing Prematurity PIP Update 2016 updated Final LA Performance Measure Submission guide_8_2 ADHD_PIP_LA_Quality_UHC101316 (2)	Full	Evidence in support of this requirement was found in the Bayou Health Plan UHC Prematurity PIP Final 822016 and the ADHD_PIP_LA_Quality_UHC101316 document.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	• Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.				
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable	Attachment B Statement of Work Amd 5 Final 3.21.16 Bayou Health Plan UHC Prematurity PIP Final_822016 Reducing Prematurity PIP Update 2016 updated Final LA Performance Measure Submission guide_8_2 ADHD_PIP_LA_Quality_UHC101316 (2)	Full	Evidence in support of this requirement was found in the Bayou Health Plan UHC Prematurity PIP Final 822016 and the ADHD_PIP_LA_Quality_UHC101316 document.	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.				
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 document.	
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2) 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 document.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
14.2.10.4	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child CAHPS surveys.	
14.2.10.5	The CAHPS survey results shall be reported to DHH or its designee for each survey question. These results may be used by DHH for public reporting. Responses will be aggregated by DHH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child CAHPS surveys.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child CAHPS surveys.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
		12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2) 12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts		CAHPS surveys.	
14.2.10.8	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Health Plan Customer Service, Global Ratings.	12430_UnitedHealthcareCommunityPlanA_DAM11453 2016 CAHPS Validated Member-Level Data File Layouts 12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2)	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child CAHPS survey.	
14.2.10.9	The MCO's vendor shall perform a DHH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to DHH on an annual basis.	12430_2016_UnitedHealthcare Community Plan_LA_Adult Medicaid_CAHPS Report and Crosstabs_v2 12470_2016_UnitedHealthcare Community Plan_LA_Child Medicaid with CCC_CAHPS Report and Crosstabs (2) **Statement:** Behavioral Health questions were incorporated into the 2016 CAPHS.	Full	Evidence in support of this requirement was found in the 12430_UnitedHealthcareCommunityPlanA_DAM11453 adult and child CAHPS survey.	
14.4	**Health Plan Accreditation**				
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not	19523_UnitedHealthcare Community Plan of	Full	Evidence in support of this requirement was provided by the	

Quality Management					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
	currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Louisiana_(Medicaid_HMO)_Summary Org19523_CommendableCert_Medicaid_HMO Young_Org19523_Medicaid_HMO 19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Score		8/30/2016 Accreditation Summary Report for United Healthcare Community Plan of Louisiana.	
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide DHH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Summary Org19523_CommendableCert_Medicaid_HMO Young_Org19523_Medicaid_HMO 19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Score	Full	Evidence in support of this requirement was provided by the 8/30/2016 Accreditation Summary Report for United Healthcare Community Plan of Louisiana and the Score Sheet.	
14.4.3	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Summary Org19523_CommendableCert_Medicaid_HMO Young_Org19523_Medicaid_HMO 19523_UnitedHealthcare Community Plan of Louisiana_(Medicaid_HMO)_Score	Full	The Accreditation Summary Report indicates an accreditation status of Commendable as of 8/31/16.	
14.5	**Member Advisory Council**				
14.5.1	The MCO shall establish a Member Advisory	PS139 Member_Advisory	Full	There is evidence to support this	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	Council Minutes UHC 3rd Qtr 2016 PS139 Member_Advisory Council Minutes UHC 4th Qtr 2015 LA - Member Advisory Plan Charter 12-19-2014		requirement in the LA Member Advisory Plan Charter and in the cover sheet for the Member Advisory Council meeting minutes. Post on-site, the plan provided MAXC meeting minutes for 1st, 2nd and 3rd quarters 2016.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	LA - Member Advisory Plan Charter 12-19-2014	Full	There is evidence to support this requirement in the LA Member Advisory Plan Charter and in the cover sheet for the Member Advisory Council meeting minutes. Post on-site, the plan provided MAXC meeting minutes for 1st, 2nd and 3rd quarters 2016.	
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	LA - Member Advisory Plan Charter 12-19-2014	Substantial	There is evidence to support this requirement in the LA Member Advisory Plan Charter and in the cover sheet for the Member Advisory Council meeting minutes. Post on-site, the plan provided quarterly MAC meeting minutes; however, there was no evidence that a family member/caregiver of a child with special health care needs attended, and per the quarterly meeting minutes provided, members comprised between 1/5 and 1/6 of the committee participants.	UHC: Agree with the recommendation.
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	LA - Member Advisory Plan Charter 12-19-2014	Full	There is evidence to support this requirement in the LA Member Advisory Plan Charter.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract	LA - Member Advisory Plan Charter 12-19-2014	Full	There is evidence to support this requirement in the LA Member Advisory Plan Charter.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	and annually thereafter.				
14.5.6.	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	PS139 Member_Advisory Council Minutes UHC 3rd Qtr 2016 PS139 Member_Advisory Council Minutes UHC 4th Qtr 2015 LA - Member Advisory Plan Charter 12-19-2014	Full	There is evidence to support this requirement in the LA Member Advisory Plan Charter and in the cover sheet for the Member Advisory Council meeting minutes. In addition, post-on-site, MAC meeting minutes were provided for Q1, Q2 and Q3.	
14.6	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Family Functional Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the appropriate exchange of fidelity reports and other quality reports. The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards are met. A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis	Evidence Based Practices Fidelity Monitoring Plan UHCCP-LAAuditProcessPolicy UHCCP - LA ACT Fidelity Monitoring Workflow Bayou ACT Fidelity Monitoring Tool 2016 UHCCP_LA Organizational Provider Site 2016 UHCCP-LA Treatment Record Tool 2016	Full	This requirement is supported by the following evidence: The Evidence Based Practices Fidelity Monitoring plan addresses this requirement for Functional Family Therapy, Multi-Systemic Therapy, Homebuilders and ACT.	

Quality Management					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by DHH. These shall take into account the monitoring responsibilities and efforts of the state agencies. Reports will be submitted to DHH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.				
14.8	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by DHH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents. The MCO, as directed by DHH, may be required to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management. The MCO shall submit reports to DHH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	UHCCP-LAAuditProcessPolicy UHCCP - LA ACT Fidelity Monitoring Workflow Bayou ACT Fidelity Monitoring Tool 2016 UHCCP_LA Organizational Provider Site 2016 UHCCP-LA Treatment Record Tool 2016	Full	The Louisiana Medicaid Provider Site and Desktop Audits policy and UHCPP LA ACT Fidelity Monitoring Workflow apply to Assertive Community Treatment (ACT). Evidence in support of this requirement was also found in the UHCCP Treatment record audit tool and in the October 2016 Adverse Incidents report.	

Reporting					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**MCO Documentation Title(s)**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
18.0	**Reporting**				
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.	18_Reporting_Facets 5-20 Data Model 18_Reporting - CSP Screen Shot_CMS1450 Claim and Member Eligibility 18_Reporting - CSP Screen Shot_CMS1500 Claim and Member Eligibility 18_Reporting - Orbit Reporting	Full	Evidence in support of the requirement to maintain a health information system is supported by 2 screen shots of individual member eligibility for Medicaid medical claims, as well as Orbit data on multiple member disenrollment, and the Facets Workflow Data model. In addition, on-site, the plan demonstrated evidence in support of monitoring grievance and appeal data, provider characteristics, and data integration, analysis and reporting to inform meeting member needs and improving the quality and integration of behavioral and physical health care provided to members.	

Fraud, Waste and Abuse					
Contract Reference	**Contract Requirement Language**	**MCO Documentation**	**Review Determination**	**IPRO Comments**	**MCO Response and Plan of Action**
15.1	**General Requirements**				
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235.				
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with DHH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at DHH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 4) The submitted Fraud and Abuse Detection and Prevention Plan was last updated 11/2014 and was in effect during the review period; the Plan has since been updated.	
15.1.3	The MCO shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, DHH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of six (6) years from the expiration date of the Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2)	
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2-3)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.				
15.1.5	MCO's employees and its contractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2) Recommendation The Plan also cites contract references, but the language in regulation 15.1.5 was not found. The Plan grants access to contact and conduct private interviews with MCO clients, employees and contractors. Consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and any other process is not addressed. The MCO agrees such language could be added at the upcoming annual review.	UHC: Agree with the recommendation.
15.1.6	The MCO and its subcontractors shall provide access to DHH and/or its designee to all information related to grievances and appeals files by its members. DHH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: United Healthcare Community Plan Louisiana Grievance System Process (p. 8)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1.7	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and DHH policy.	integrity_of_claims,_reports_and_representations_to_government_entities	Full	Requirement addressed by: UnitedHealth Group's Integrity of Claims, Reports and Representations to Government Entities Policy Several attestations were submitted: 148 UHC 2016 09 (Medicaid Program Integrity Attestation) 149 UHC 2016 Q2 AT (Attestation for Reports) 170 UHC A AT (Attestation for Reports)	
15.1.8	The MCO will report to DHH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, contractor, or contractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program to their designated Program Integrity contact.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8). Reporting is done via the URL http://new.dhh.louisiana.gov/index.cfm/page/219 (Provider Fraud Form)	
15.1.9	The MCO shall have surveillance and utilization control programs and procedures (42 CFR §456.3, §456.4, §456.23) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	FWA End to End Process	Full	Requirement addressed by: FWA End to End Process	
15.1.10	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the	LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11 2015_Final Clean	Full	Requirement addressed by: LA Medicaid and CHIP Program Regulatory Requirements Appendix (Medical Subcontractor) 11/2015 (Section 4.3, p. 5)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	disclosure form, at least once annually, and at any time upon request.				
15.1.11	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.	LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11 2015_Final Clean	Full	Requirement addressed by: LA Medicaid and CHIP Program Regulatory Requirements Appendix (Medical Subcontractor) 11/2015 (Section 4.11, p. 9-10)	
15.1.12	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 100,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 5) UHC FWA Organizational Chart	
15.1.13	The MCO is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	SOP__Prohibition_to_Recoup_or_Withhold	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers 2/2015	
15.1.13.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	SOP__Prohibition_to_Recoup_or_Withhold	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers (p. 1)	
15.1.13.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	SOP__Prohibition_to_Recoup_or_Withhold	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
				(p. 2)	
15.1.13.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	SOP__Prohibition_to_Recoup_or_Withhold	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers (p. 2)	
15.1.14	This prohibition described above in Section 15.1.13 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to DHH.	SOP__Prohibition_to_Recoup_or_Withhold	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers (p. 2)	
15.1.15	The MCO shall comply with all federal and state requirements regarding fraud waste, and abuse, including but not limited to Sections 1128, 1156, and 1902(a)(68) of the Social Security Act.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Standard Operating Procedure Prohibition to Recoup or Withhold Improperly Paid Funds to Providers (p. 2)	
15.1.16	**Reporting and Investigating Suspected Fraud and Abuse**				
15.1.16.1	The MCO shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.				
15.1.16.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (subcontractors p. 9) FWA End to End Process	
15.1.16.3	The MCO shall notify MFCU and DHH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide simultaneous and timely updates to MFCU and DHH when the concerns and/or allegations of any tips are authenticated.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 5-6)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.1.16.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to DHH and the appropriate agency as follows:	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.16.3.	
15.1.16.4.1	All tips (any program integrity case opened within the previous two (2) weeks) shall be reported to DHH and MFCU;	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.16.3. Timeframes are more stringent than required.	
15.1.16.4.2	Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.16.3.	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.16.3.	
15.1.16.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.16.3.	
15.1.16.5	The MCO shall utilize a Fraud Reporting Form deemed satisfactory by the agency to whom the report is to be made under the terms of this Contract.	MCO Fraud Referral Template	Full	Requirement addressed by: Louisiana Medicaid MCO Suspected Provider Fraud Referral Form	
15.1.16.6	The MCO shall be subject to a civil penalty, to be imposed by the DHH, for willful failure to report fraud and abuse by recipients, enrollees, applicants, or providers to DHH MFCU, as appropriate.				
15.1.16.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6)	
15.1.16.7.1	Contact the subject of the investigation about any matters related to the investigation;	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6)	
15.1.16.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6)	
15.1.16.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	incident.				
15.1.16.8	The MCO shall promptly provide the results of its preliminary investigation to DHH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8)	
15.1.16.9	The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2) <u>Recommendation</u> Plan language pertains to all MCO employees and contractors, and does not specify those with expertise in the administration of the program and /or in medical or pharmaceutical questions. The MCO agrees such language could be added at the upcoming annual review.	
15.1.16.10	The MCO is to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2)	
15.1.17	The State shall not transfer its law enforcement functions to the MCO.				
15.1.18	The MCO, subcontractor and providers, whether contract or non-contract, shall, upon request and as required by this Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and medical records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by this Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of any	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	contractor, subcontractor or provider, whether contract or non-contract, during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.				
15.1.19	The MCO and/or subcontractors shall include in any of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11 2015_Final Clean	Full	Requirement addressed by: LA Medicaid and CHIP Program Regulatory Requirements Appendix (Medical Subcontractor) 11/2015 (Section 4.7, p. 8)	
15.1.20	The MCO shall notify DHH when the MCO denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	Fraud and Abuse Detection and Prevention FINAL	Full	Evidence submitted by the MCO (Fraud and Abuse Detection and Prevention (p. 5)	
15.1.21	Except as described in Section 15 of this Contract, nothing herein shall require the MCO to ensure non-contract providers are compliant with Louisiana Medicaid contracts or state and/or federal law.				
15.1.22	In accordance with the Affordable Care Act and Louisiana Medicaid policy and procedures, the MCO shall report overpayments made by DHH to the MCO as well as overpayments made by the MCO to a provider and/or subcontractor.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 9)	
15.1.23	The MCO shall have at least one (1) full-time investigator or full-time equivalent per 100,000 enrollees or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 15.1.12.	
15.2	**Fraud and Abuse Compliance Program**				
15.2.1	In accordance with 42 CFR §438.608(a), the MCO shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention FWA End to End Process	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
15.2.2	In accordance with 42 CFR §438.608(b)(2), the MCO shall designate a compliance officer and compliance committee that have the responsibility and authority for carrying out the provisions of the compliance program. These individuals shall be accountable to the MCO's board of directors and shall be directly answerable to the Executive Director or to the board of directors and senior management. The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer.	LA Compliance Comm Charter 2014-2015	Full	Requirement addressed by: LA Medicaid Oversight Compliance committee Charter 2014-2015 UHC FWA Organizational Chart	
15.2.3	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to DHH for approval at least thirty (30) days in advance of making them effective. DHH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 2)	
15.2.3.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 1) United Healthcare Government Programs Compliance Program	
15.2.3.2	Effective lines of communication between the Program Integrity Officer and the MCO's employees, providers and contractors enforced through well-publicized disciplinary guidelines;	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 5, 7)	
15.2.3.3	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 8-9)	
15.2.3.4	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity Officer, to receive them. Several independent reporting paths shall be created for the reporting of	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 5-6)	

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	fraud so that such reports cannot be diverted by supervisors or other personnel;				
15.2.3.5	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 2)	
15.2.3.6	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to DHH and/or the U.S. Office of Inspector General.	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 5)	
15.2.3.7	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 1, 5, 7, 8)	
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 7)	
15.2.3.9	Effective education for the Program Integrity Officer, program integrity investigators, managers, employees, providers and members to ensure that they know and understand the provisions of MCO's compliance plan;	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 4-5)	
15.2.3.10	Fraud, Waste and Abuse Training shall include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.	2016-2017 UHC Govt Programs Compliance Program	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 4)	
15.2.3.11	MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse • Procedures for timely consistent exchange of information and collaboration with DHH;	2016-2017 UHC Govt Programs Compliance Program Compliance_Curriculum Tips for Responding to Regulators Email to HP Staff 4.3.16 UHC FWA Org Chart	Full	Requirement addressed by: United Healthcare Government Programs Compliance Program (p. 4-5) United Health Group Enterprise Compliance Training – Curriculum as of 6/1/2014 Tips for Responding to Regulators – Email to MCO staff 4/3/2016 UHC FWA Organizational Chart	

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	• Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §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 Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.				
15.3	**Prohibited Affiliations**				
15.3.1	In accordance with 42 CFR 438.610, the MCO is prohibited from knowingly having a relationship with: An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.				
15.3.2	The MCO shall comply with all applicable provisions of 42 CFR 438.610 pertaining to debarment and/or suspension. The MCO shall screen all employees and contractors to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.	Employee Sanctions Monitoring Policy	Full	Requirement addressed by: Employee Sanctions Monitoring Policy	
15.3.3	The MCO shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); • Louisiana Adverse Actions List Search; • The System of Award Management (SAM); and • Other applicable sites as may be determined by DHH	provider_sanctions_monitoring_pnp	Full	Requirement addressed by: Provider Sanctions Monitoring Policy and Procedure (p. 5) This Optum document applies to UnitedHealth group business segments.	

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15.3.4	The MCO shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to DHH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8) Recommendation Submitted evidence of compliance on page 8 references 1128A (a) of the Social Security Act; reference to 42 CFR 1003.102 (a) (2) is not found at this location. The MCO should include in its policy contract requirement language; specifically, regarding Medicaid payment to another provider who is not excluded (pharmacy).	UHC: Agree with the recommendation.
15.3.4.1	An individual who is an affiliate of a person described above include: • A director, officer, or partner of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations.	Fraud and Abuse Detection and Prevention FINAL	Substantial	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8, labeled 15.3.4.1). The Plan addresses only MCO employee, network providers, contractor or contractor employee. Though section 1128A of the Social Security Act is cited; section (a)(4)(A) generally addresses ownership. Recommendation Language pertaining to directors, officers, partners, 5% or more ownership, and provision of services material to the MCO's obligations should be considered for inclusion in the Plan.	UHC: Agree with the recommendation.
15.3.4.2	The MCO shall notify DHH within three (3)	Fraud and Abuse Detection	Full	Requirement addressed by:	

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	days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	and Prevention FINAL		Fraud and Abuse Detection and Prevention (p. 8 and labeled 15/3/2)	
15.4	**Payments to Excluded Providers**				
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for emergency services ; and	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6)	
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 9)	
15.5	**Reporting**				
15.5.1	In accordance with 42 CFR 455.1(a)(1) and 455.17, the MCO shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and DHH within three (3) business days of discovery, taking prompt corrective actions and cooperating with DHH in its investigation of the matter(s). Additionally, the MCO shall notify DHH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, contractor or contractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 7-8)	
15.5.2	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:				
15.5.2.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (defined at 42 CFR 455.14);	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8)	
15.5.2.2	Number of complaints reported to the	Fraud and Abuse Detection	Full	Requirement addressed by:	

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	Program Integrity Officer; and	and Prevention FINAL		Fraud and Abuse Detection and Prevention (p. 8)	
15.5.2.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide DHH, at a minimum, the following: • Provider name and ID number; • Source of complaint; • Type of complaint; • Nature of complaint; • Approximate range of dollars involved if applicable; and • Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8) http://new.dhh.louisiana.gov/index.cfm/page/219 (MCO Suspected Provider Fraud Referral Form)	
15.5.3	The MCO, through its compliance officer, shall attest to DHH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 8) 148 UHC 2016 09 (Medicaid Program Integrity Attestation)	
15.6	**Medical Records**				
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members. The MCO shall have policies and procedures to maintain, or require MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	Provider Manual - Medical Record Review Provider Manual - Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41, Credentialing and Recredentialing p. 109) <u>Recommendation</u> Beyond Provider Manual sections meeting all requirements, the MCO could submit Medical Record Review P/P for subsequent compliance reviews.	
15.6.1.1	Accurate and legible;	Provider Manual - Medical Record Review Provider Manual - Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41, Credentialing and Recredentialing p. 109)	
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated	Provider Manual - Medical Record Review	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 38 of p. 38-	

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	or treated, and is accessible for review and audit; and	Provider Manual - Medical Record Audit Information		41)	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	Provider Manual - Medical Record Review Provider Manual - Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 38 of p. 38-41)	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	Provider Manual - Medical Record Review Provider Manual - Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 38-41, Credentialing and Recredentialing p. 109). See following requirements.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	Provider Manual - Medical Record Review Provider Manual - Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41)	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 38 and 40 of p. 38-41)	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41)	
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (p. 38-41)	
15.6.2.5	Referrals including follow-up and outcome of referrals;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 39 of p. 38-41, Credentialing and Recredentialing p. 109))	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 39 of p. 38-41)	
15.6.2.7	Signed and dated consent forms (as applicable);	Provider Manual- Medical Record Review	Full	Requirement addressed by: Louisiana Acute Care Provider	

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		Provider Manual-Medical Record Audit Information		Manual (specifically p. 40 of p. 38-41)	
15.6.2.8	Documentation of immunization status;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41)	
15.6.2.9	Documentation of advance directives, as appropriate;	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41, Credentialing and Recredentialing p. 109)	
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	Provider Manual- Medical Record Review Provider Manual-Medical Record Audit Information	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41)	
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.	Provider Manual- Medical Record Review	Full	Requirement addressed by: Louisiana Acute Care Provider Manual (specifically p. 40 of p. 38-41)	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	LA Physical Health Handbook_v7n 6-23-16	Full	Requirement addressed by: Member Handbook for Physical Health Services (p. 53)	
15.6.4	All documentation and/or records maintained by the MCO or any and all of its network providers shall be maintained for at least six (6) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an	Record Retention Schedule USA Oct 2016 Records Retention Policy Provider Manual- Medical Record Review Provider Manual-Medical	Full	Requirement addressed by: Record Retention Schedule USA (p. 10-12, medical records Age of Majority + 10 years / Date of Last Service + 10 years) <u>Recommendation</u> The plan's Louisiana Acute Care Provider Manual (p. 38) requires a	UHC: Disagree with the recommendation - This requirement is included in the Medicaid Regulatory Appendix which is part of every network provider agreement. Section 4.4(d) See document: LA

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	administrative or judicial action brought by or on behalf of the state or federal government.	Record Audit Information		record retention policy, however, the policy should be updated to reflect retention of at least six years. The MCO disagreed with this recommendation. Subsequent to the draft report, the MCO indicated that this requirement is included in the Medicaid Regulatory Appendix. Changed from "Substantial" to "Full."	Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11 2015_Final Clean
15.7	**Rights of Review and Recovery by MCO and DHH**				
15.7.1	Each MCO is responsible for investigating possible acts of provider fraud, abuse, and waste for all services under this contract, including those services that the MCO subcontracts to outside entities.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 1, entire document).	
15.7.2	The MCO has the exclusive right of review and recovery for twelve 365 days from the original date of service of a claim to initiate a "complex" review of such claim to determine a potential overpayment and/or underpayment by delivering such notice to the provider in writing of initiation of such a review. A "complex" review is one for which the MCO's review of medical, financial and/or other records, including those on-site where necessary to determine the existence of an improper payment.. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 1). This Optum policy defines specific Louisiana Acute contractual requirements.	
15.7.3	All "complex" reviews must be completed within one hundred and twenty (120) days of the date of the notice to the provider unless an extension is authorized by the Department. This review period is inclusive of all provider notification, health plan document review, and including any Rights of Recovery PnP provider appeal or rebuttal process. The MCO shall	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 1-2)	

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	notify the Department, at least on a monthly basis, the results of "complex" reviews that include as well as instances of suspected fraud and/or a collection status.				
15.7.4	The MCO shall not retain the exclusive right of review and/or recovery beyond 365 days from the original date of service of a claim for a "complex" review, but the MCO may conduct audits of providers' claims for a five (5) year period from the date of service of a claim. Results of the audit reviews must be communicated to the Department at least monthly in instances of suspected fraud or requiring collection. The collected funds from those reviews are to remain with the MCO.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.5	If the MCO does not initiate action through official notification to a provider with respect to a "complex" claim review within 365 days from the original date of service of the claim or fails to collect at least a portion of the "complex" claim review recovery after 365 days from the date of notice to the Department of the collection status, unless in either scenario an extension is authorized by the Department or its agent may recover from the provider any overpayments which they identify and said recovered funds will be returned to the State.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.6	The MCO shall not retain the exclusive right of review and/or recovery from the initial date of service of a claim for which the Department or its agent identifies improper payment(s) as a result of "automated" claims reviews. An "automated" review is one for which an analysis of the paid claims is sufficient to determine the existence of an improper payment(s) where as no additional documentation is required to be submitted from the provider to determine the existence of an overpayment.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.7	DHH may recover from the provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.8	DHH must notify the MCO of an identified	Right of Recovery PnP	Full	Requirement addressed by:	

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	improper payment from a "complex" or "automated" review prior to notifying any provider(s). The MCO shall have thirty (30) calendar days from the date of notification of potential improper payment(s) to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department or its agent.			Right of Recovery Policy and Procedure (p. 2)	
15.7.9	The MCO shall not correct claims not initiate an audit on the claims upon notification by the Department or its agent unless directed to do so by the Department.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.10	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department of its agent will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. The MCO shall collect and refund any amounts collected to the Department. Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 2)	
15.7.11	There will be no DHH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Bayou Health Contract period of for providers for which no MCO relationship existed.	Right of Recovery PnP	Full	Requirement addressed by: Right of Recovery Policy and Procedure (p. 3)	
	Additional PE-Related RFP Sections				
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 6) citing 42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2), LA Medicaid and CHIP Program Regulatory Requirements Appendix	

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	12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.			(Medical Subcontractor) 11/2015 (Section 4.11, p. 10) describes HHS-OIG website search by name prior to contract signature. Employee Sanctions Monitoring Policy describes website search prior to employment.	
4.1.4	The MCO shall comply with DHH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of DHH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide DHH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	Employee_Background_Checks_Policy	Full	Requirement addressed by: Employee Background Checks Policy 148 UHC 2016 09 (Medicaid Program Integrity Attestation)	
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. DHH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 9)	
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and	Fraud and Abuse Detection and Prevention FINAL 149 UHC 2016 Q2 AT	Full	Requirement addressed as cited at 4.1.2. Fraud and Abuse Detection and Prevention (p. 6) cites Section 1128 or Section 1128A of the Social Security Act and 42 CFR §438.214(d). LA Medicaid and CHIP Program Regulatory Requirements Appendix (Medical Subcontractor) 11/2015 (Section 4.11, p. 10) describes HHS-OIG website search by name prior to	

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	Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.			contract signature.	
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed as cited at 4.1.2 and 7.6.2. Fraud and Abuse Detection and Prevention (p. 6) cites §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) and the Federal Acquisition Regulation.	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of DHH or its authorized agent(s).	integrity_of_claims,_reports_and_representations_to_government_entities LA Medicaid_CHIP Reg Appendix (Medical Subcontractor) 11 2015_Final Clean	Full	Requirement addressed by: LA Medicaid and CHIP Program Regulatory Requirements Appendix (Medical Subcontractor) 11/2015 (Section 4.11, p. 10) and Integrity of Claims, Reports and Representations to Government Entities Policy, which cites compliance with state and federal laws, but does not specify provider payment holds under the authority of DHH. <u>Recommendation</u> Language regarding DHH provider payment holds should be added to the relevant P/P; the MCO reports this is contained in the updated Plan.	
17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	provider_sanctions_monitoring_pnp	Full	Employee Sanctions Monitoring Policy (Section 1.4, p. 3)	
18.1	Federal laws require full disclosure of ownership, management, and control of	170 UHC 2016 A AT	Full	Requirement addressed by: 170 UHC A AT (Attestation for	

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Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to DHH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.			Reports – Medicaid Ownership and Disclosure Form)	
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to DHH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by DHH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 10-11)	
18.3	**Report of Transactions with Parties in Interest –** 18.3.1 The MCO shall report to DHH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p. 11-12)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. DHH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest. 18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.				
18.7	The MCO shall furnish DHH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	Fraud and Abuse Detection and Prevention FINAL	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p.12)	
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to nonprocurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the	provider_sanctions_monitoring_pnp Employee Sanctions Monitoring Policy 148 UHC 2016 09	Full	Requirement addressed by – Employee Sanctions Monitoring Policy describes website search prior to employment and monthly. Provider Sanctions Monitoring Policy and Procedure describes monthly monitoring; Requirement addressed as cited at 15.3.4. Recommendation as cited at 15.3.4.	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	following websites: Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank (HIPDB) http://www.npdb-hipdb.hrsa.gov/index.jsp; the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.dhh.la.gov/; and/or the System for Award Management, http://www.sam.gov . 25.13.2 The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to DHH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).				
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual;	Non covered codes	Full	Requirement addressed by: Fraud and Abuse Detection and Prevention (p.10)	

Fraud, Waste and Abuse					
Contract Reference	Contract Requirement Language	MCO Documentation	Review Determination	IPRO Comments	MCO Response and Plan of Action
	Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.				