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Appendix JJ	**Transition Period Requirements (Only those related to PI or PE)**				
Contract Start-up	The MCO will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Period. An updated and detailed Transition Implementation Plan will be due to DHH within thirty (30) days from the date the contract is signed by the MCO or the date when the Readiness Review process begins, whichever is sooner.	Met. The plan submitted their Readiness Review Implementation Project Plan dated 12/09/2014.	Appendix JJ United_LA_Acute_Readiness_Review_Work_Plan__12_8_2014.mpp	Entire Document	N/A
Admin and Key MCO Personnel	No later than fourteen (14) days after the Contract Effective Date, the MCO must designate and identify Key MCO Personnel that meet the requirements of the contract. The MCO shall supply DHH with resumes of each Key MCO Personnel as well as organizational information that has changed relative to the MCO proposal , such as updated job descriptions and updated organization charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the MCO is using a Subcontractor(s), the MCO must also provide the organization chart for each Subcontractor(s).	Met. The plan submitted the resumes for the following key personnel: 1) CEO – April D Goleno 2) VP of Quality – Angela Olden 3) Chief Medical Officer - Antoinette Katherine Cefalu Logarbo, Charles Freed 4) State Fair Hearing Coordinator - Coudra Costict 5) Director of Network Strategy – Deborah Tillman 6) CIO – Gabriel Moreno 7) COO/CFO – Karl Lirette 8) Contract Compliance Officer/Organization Compliance Officer – Larry Smith 9) Associate Director of Clinical Services – Linda Rintala The plan submitted their organization chart demonstrating that key personnel have been appointed. The plan submitted the organization chart for the MIS department. The plan submitted the organization chart for the following subcontractors – • CareCore National • LogistiCare LA • March Vision Care • Optum Insight	Job Descriptions in Key Personnel Folder Resumes in Key Personnel Folder MIS Org Chart and Job Description in Key Personnel Folder Subcontractor organization charts in Key Personnel Folder		

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		• Optum Physical Health • Optum Rx			
Other Information	Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Louisiana regulatory entity or a regulatory entity in another state within the last three (3) years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions, or fines, if any, were related to Medicaid or CHIP programs. DHH may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the MCO.	Met. The plan submitted a list of all regulatory sanctions and/or fines imposed by any federal or state regulatory entity (including LA state) since 08/03/2009. The list contains a description of each sanction/fine, and indicates the product line to which the sanction/fine was related.	LA Regulatory Actions and Sanctions PDF Regulatory Action Folder Almost all are Medicaid	Entire Document	N/A
Operation Readiness	As part of the Fraud and Abuse Compliance Plan, the MCO shall: Designate a compliance officer and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means MCO staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within the MCO.	Met. Page 6 of the P/P Fraud and Abuse Prevention and Detection states that "All UHCCS employees are required to read and follow the UnitedHealth Group Code of Conduct – Our Principles of Ethics and Integrity and the Employee Handbook and to familiarize themselves with the policies and procedures that have been established in each functional area to detect, deter and report fraud and abuse. Additionally, as required by the Deficit Reduction Act of 2005, all Health Plan employees must be advised of this Fraud and Abuse Compliance Plan. UHCCS employees also receive fraud and abuse awareness training as required by regulation, law, or contract or by company policy. Annual Fraud and Abuse Training is required by UnitedHealth Group and is delivered via LearnSource®, which is an on-line training program. The Compliance Officer will monitor annual Fraud and Abuse Training to ensure essential Health Plan staff participated. This includes staff persons who supervise staff in data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and others who are involved in decision-making and the administration	P&P Fraud and Abuse Prevention and Detection 15.1 Compliance Committee Charter FWA 15.2 - B	Education and Training	

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		of the fraud and abuse detection program at the Health Plan." The plan submitted a copy of their Compliance Committee Charter. The charter details the committee's objective, which is to "is to assist the Plan Compliance Officer and Plan President in fulfilling their responsibilities of developing, implementing, and monitoring the Louisiana Compliance Program" and contains sections on committee membership, review process, roles and responsibilities, committee structure and operations.			
Operation Readiness	Designate an officer within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.	Met. Larry Smith is the current Contract Compliance Officer and also the Organization Compliance Officer (Program Integrity Officer). Page 3 of the P/P Fraud and Abuse Prevention and Detection states that "At the Health Plan, the Program Integrity Officer is accountable for overseeing the fraud and abuse program, which includes a written Fraud and Abuse Compliance Plan." The plan submitted the job description of the Program Integrity Officer, who "Oversees monitoring and enforcement of the fraud, waste and abuse compliance program pursuant to state and federal rules and regulations. Executes the provisions of the compliance plan, including fraud, waste, and abuse policies and procedures, investigating unusual incidents and implementing any corrective action plan".	Compliance Committee Charter FWA 15.2 – B Resume and job description in Key Personnel Folder P&P Fraud and Abuse Prevention and Detection 15.1	Responsibilities and Accountabilities	
Operation Readiness	The MCO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements.	Met. The Fraud and Abuse Prevention and Detection P/P (p.8) states that "The Health Plan understands it is accountable for these requirements and will ensure that if any services or functions are subcontracted to another entity, that the subcontractor will be held to the same requirements."	P&P Fraud and Abuse Prevention and Detection 15.1	Subcontracting	
15.1	**General Requirements**				
15.1.1	The MCO shall comply with all state and federal laws and regulations relating to fraud, abuse and				

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	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.	Met. The Fraud and Abuse Prevention and Detection P/P (p.3) states that "The Program Integrity Officer, and the CEO or COO shall meet with DHH and the Louisiana Office of Attorney General's Medicaid Fraud Control Unit (MFCU) quarterly, annually, and upon request, to discuss fraud, waste, abuse, neglect and overpayment issues. The Program Integrity Officer will be the primary point of contact."	P&P Fraud and Abuse Prevention and Detection 15.1	Responsibilities and Accountabilities	
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.	Met. The Fraud and Abuse Prevention and Detection P/P (p.2) states that "The Health Plan 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. The HHS, the State Auditor's Office, the Office of 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 extension 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, at any time during normal business hours."	P&P Fraud and Abuse Prevention and Detection 15.1 UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program FWA 15.2 - B	Detection and Reporting	pg. 20-21
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 directly pertinent to a specific program for the purpose of making audits, examinations, excerpts	Met. Page 2 of the Fraud and Abuse Prevention and Detection P/P contains this contract language.	P&P Fraud and Abuse Prevention and Detection 15.1 UnitedHealthcare Government Programs	Procedure	Pg. 10, 20-

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	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.		Anti-Fraud, Waste and Abuse Program FWA 15.2 - B		21
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.	Met. Page 9 of the UnitedHealthcare Government Programs Corporate Responsibility and Compliance Program document states that "UHC Government Programs cooperates with law enforcement and regulatory agencies in the investigation or prevention of FWA". Page 21 of the UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program document states that the "UHC Government Programs works closely with federal and state law enforcement authorities in combating fraud, waste and abuse and appropriate refers suspected fraud, waste and abuse matters to such authorities for criminal prosecution and/or civil enforcement action. The SIU collaborates with UHC Government Programs Legal in serving as the 'face to law enforcement' for all fraud investigations. In addition to criminal prosecutions, UHC Government Programs also works with federal and state law enforcement authorities in joint civil recovery efforts." Page 2 of the Fraud and Abuse Prevention and Detection P/P states, "The Health Plan 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."	UnitedHealthcare Government Programs Corporate Responsibility and Compliance Program FWA 15.2 - B UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program FWA 15.2 - B		pg. 9 pg. 14, 18, 21
15.1.6	The MCO shall provide access to DHH and/or its designee to all information related to grievances	Met. The Louisiana Grievance System Process P/P (p.7) states			

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	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.	"UnitedHealthcare must maintain records for all appeals and grievances, including the resolution, for a period of six years. The records must be made available upon request by DHH."	Louisiana Grievance System Process P&P 15.1	Section: Document Retention	
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.	Met. The plan submitted a sample of their Attestation for Reports that were signed and dated by the COO. The plan has a P/P called UnitedHealth Group's Integrity of Claims, Reports and Representations to Government Entities, which addresses the Federal False Claims Act, Federal Fraud Civil Remedies and State False Claims Acts. This P/P also details the managers' responsibilities, the business organization's responsibilities and UnitedHealth Group's responsibilities in implementing the policy.	UnitedHealth Group Integrity of Claims, Reports and Representations to Government Entities 15.1 Attestation for Reports 15.1		
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 through the following url: http://new.dhh.louisiana.gov/index.cfm/page/219.	Met. The Fraud and Abuse Prevention and Detection P/P lists all the required reports by the DHH related to FWA and the timeframe for reporting. Exclusion databases are in this list and the plan is aware that they have to report this to the state within 3 business days.	P&P Fraud and Abuse Prevention and Detection 15.2 - B	External Reporting	
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.	Met. The plan submitted P/P UCSMM.06.10 Clinical Review Criteria (UM policy). Contained are the guidelines that ensure sound clinical evidence for utilization management decision; provide consistent application of evidence and consider consumer circumstances when conducting reviews. In this P/P, the plan states that "The utilization management program will use evidence-based, clinical review criteria to support clinical review decisions. Staff will apply the clinical review criteria consistently in accordance with written procedures and with consideration for individual consumer needs. Qualified physicians will develop the clinical review criteria based on current clinical principals. The organization and actively practicing physicians with knowledge relevant to	Clinical Review Criteria UCSMM 0610 15.1 P&P Fraud and Abuse Prevention and Detection 15.2 -B Government Programs Corporate Responsibility and Compliance Program 15.2 -B		Pages 6-8

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		the clinical review criteria will evaluate them at least annually, and the utilization management program medical director or designee will approve them." Page 4 of the Fraud and Abuse Prevention and Detection P/P states that the "established policies, procedures and internal controls in each functional area are designed to create an environment to deter and detect fraudulent or abusive conduct in a timely manner. In most instances we expect such inappropriate activity to be detected by the regular management oversight of our own business activities and of the activities of our providers, members and contractors or by claims processing reviews and audits. However, instances of suspected fraud may be brought to light in a number of other ways, such as: reports from providers and members, notification of alleged or suspected fraud and abuse by law enforcement or regulatory authorities, or by internal or governmental audits and reviews of our operations."			
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 disclosure form, at least once annually, and at any time upon request.	Met. Item 3.22 of the Provider Agreement Appendix states, "Provider shall comply with and submit to United disclosure of information in accordance with the requirements specified in 42 CFR Part 455, Subpart B (42 CFR §§ 455.100 – 106), as may be amended from time to time." The plan has a Disclosure Reporting Process P/P, which describes how UHC Community Plan collects Disclosure of Ownership and Control Interest Statement Form. This P/P describes collection, evaluation, storage, tracking, and reporting activities related to this process for all provider types participating in the plan. The plan submitted a copy of the Provider Entity Disclosure Form and the Individual Provider Disclosure Form.	Regulatory Appendix 15.1 UnitedHealthcare Disclosure Form 15.1 Disclosure Reporting Process P&P 15.1	3.22	
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	Met. Item 3.37 of the Provider Agreement Appendix states, "Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider	Regulatory Appendix 15.1	3.11	

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	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.	in Provider's performance of the Agreement. Provider understands that payment of a claim by United or the State is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to United constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim may be temporarily suspended if the State or United provides notice that a credible allegation of fraud exists and there is a pending investigation." The plan submitted a copy of the Provider Entity Disclosure Form and the Individual Provider Disclosure Form.	Provider Disclosure Form Entity 15.1 Employee Background Check Policy 15.1		
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.	Met. Page 4 of the Fraud and Abuse Prevention and Detection P/P states "We will have at least one (1) full-time fraud, waste and abuse investigator physically located in the state for every 100,000 members, or fraction thereof."	P&P Fraud and Abuse Prevention and Detection 15.2 - B UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program FWA 15.2 - B	Detection and Reporting Pg. 13-19	
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:	Met. The Prohibition to Recoup or Withhold Improperly Paid Funds to Providers P/P contains the exact language as per this contract requirement.			
15.1.13.1	The improperly paid funds have already been recovered by the State of Louisiana, either by	Met. The Prohibition to Recoup or Withhold Improperly Paid	SOP Prohibition on Recoupment 15.1		

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	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	Funds to Providers P/P contains the exact language as per this contract requirement.			
15.1.13.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	Met. The Prohibition to Recoup or Withhold Improperly Paid Funds to Providers P/P contains the exact language as per this contract requirement.	SOP Prohibition on Recoupment 15.1		
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.	Met. The Prohibition to Recoup or Withhold Improperly Paid Funds to Providers P/P contains the exact language as per this contract requirement.	SOP Prohibition on Recoupment 15.1		
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. The MCO shall confer with DHH before initiating any recoupment or withhold of any program integrity related funds. (See Section 15.7) to ensure that the recovery recoupment or withhold is permissible. 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.	Met. The Prohibition to Recoup or Withhold Improperly Paid Funds to Providers P/P contains the exact language as per this contract requirement.	SOP Prohibition on Recoupment 15.1		
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.	Met In the Anti-FWA Program document (p.9), the plan states that their UHC Government Programs is committed to compliance with federal and state fraud, waste and abuse regulatory requirement applicable to each of its plan type. Page 1 of the Fraud and Abuse Prevention P/P (LA-CE-Policy 001) contains this contract language.	UnitedHealthcare Government Programs Corporate Responsibility and Compliance Program FWA 15.2-B		Pg. 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,	Met.	UnitedHealthcare Government Programs		Pg. 13-17

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	investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21).	In the Anti-FWA Program document (p.13), UHC details how the program is organized and staffed, i.e. Special Investigative Unit (SIU) and the Payment Integrity department, and describes each department's role. In p.15 of the same document, UHC describes how departments perform prospective anti-FWA functions, and how each department partners with the SIU, where prospective detection and audit activity identifies opportunity for retrospective investigations of FWA. In p.17, UHC describes in detail how retrospective anti-FWA activities are conducted. The plan submitted Optum Insight's Prospective Investigation and Clinical Review P/P, which provides the steps, throughout the pre-payment investigation of detected claims to be followed by the Prospective Investigations teams. The plan submitted Optum Insight's Retrospective Investigations P/P which defines the roles and responsibilities as well as outlines the procedures followed by the Retrospective team when performing a retrospective or post-payment review of provider's claims, which have been detected as suspected as fraudulent.	Anti-Fraud, Waste and Abuse Program 15.2 - B Optum P&P Making a TIP referral 15.2 - B Optum P&P Handling Suspect Tips and Referrals 15.2-B Optum P&P Retrospective Investigations 15.1		
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.	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately. Optum's Making a TIP referral P/P outlines the procedures to make a referral of suspected FWA for further investigation. Optum's Handling Suspect Tips and Referral – Triage	Fraud and Abuse Prevention and Detection P&P 15.1 Optum P&P Making a TIP referral 15.2 - B Optum P&P Handling Suspect Tips and Referrals 15.2 - B Optum P&P Retrospective Investigations 15.1	Detection and Reporting	

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		Process P/P ensures all tips and referral are triaged and assigned within 2 business days.			
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:	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware of their responsibility and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately.	Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
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;	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware of their responsibility and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately.	Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
15.1.16.4.2	Suspected fraud and abuse in the administration of the program shall be reported to DHH and MFCU;	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware of their responsibility and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately.	Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
15.1.16.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to DHH and MFCU; and	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware of their responsibility and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately.	Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	

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15.1.16.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately to DHH and local law enforcement.	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states that "Reports of all tips of confirmed or suspected fraud, waste and abuse shall be reported to DHH and the MFCU." It is evident from this P/P that the plan is aware of their responsibility and has a procedure in place to notify the DHH and MFCU of any FWA tips immediately.	Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
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.	N/A.	TBD by DHH		
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:	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states, "After receiving information about suspected or confirmed fraud or abuse, a preliminary investigation will be conducted to determine appropriate actions. Unless DHH, MFCU or its designee provides written approval, UHCCS will not contact the subject of the investigation, attempt to enter an agreement or settlement, or accept anything of value from the subject of the investigation."	Retrospective Investigations P&P 15.1 Prospective Investigation and Clinical Review P&P	3.0 3.2	
15.1.16.8	Contact the subject of the investigation about any matters related to the investigation;	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states, "After receiving information about suspected or confirmed fraud or abuse, a preliminary investigation will be conducted to determine appropriate actions. Unless DHH, MFCU or its designee provides written approval, UHCCS will not contact the subject of the investigation, attempt to enter an agreement or settlement, or accept anything of value from the subject of the investigation."	Fraud and Abuse Prevention and Detection	Detection and Reporting	Page 5
15.1.16.9	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	Met. The Fraud and Abuse Prevention and Detection P/P (p.5)	Fraud and Abuse Prevention and Detection	Detection and Reporting	Page 5

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		states, "After receiving information about suspected or confirmed fraud or abuse, a preliminary investigation will be conducted to determine appropriate actions. Unless DHH, MFCU or its designee provides written approval, UHCCS will not contact the subject of the investigation, attempt to enter an agreement or settlement, or accept anything of value from the subject of the investigation."			
15.1.16.10	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) states, "After receiving information about suspected or confirmed fraud or abuse, a preliminary investigation will be conducted to determine appropriate actions. Unless DHH, MFCU or its designee provides written approval, UHCCS will not contact the subject of the investigation, attempt to enter an agreement or settlement, or accept anything of value from the subject of the investigation."	Fraud and Abuse Prevention and Detection	Detection and Reporting	Page 5
15.1.16.11	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.	Met. The Fraud and Abuse Prevention and Detection P/P contains this contract language (p.8).	Retrospective Investigations P&P 15.1	3.0	
15.1.16.12	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.	Met. The Fraud and Abuse Prevention and Detection P/P (p.2) states, "The Health Plan 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." In addition, "The Health Plan and its subcontractors shall make all program and financial records and service delivery sites open to the representatives 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 <u>have the right to timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers and records, contact and conduct private interviews with Health Plan clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified</u>	Regulatory Appendix 15.1 Prospective Investigation and Clinical Review P&P	3.14 3.2	

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		by the Contract."			
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 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.	Met. The Fraud and Abuse Prevention P/P (p.2) contains this contract language. The Regulatory Requirement Appendix of the Provider Agreement only deals with the providers' responsibility to maintain and retain administrative, financial and programmatic records, supporting documents, statistical records, medical records, other records of Covered Persons relating to the delivery of care or services under the State Contract, and such other records as required by DHH (item 3.5). In addition, this document also notes that providers shall acknowledge that State and Federal agencies shall have the right to audit, inspect (announced or unannounced) any records pertinent to the State contract without any restrictions (item 3.8).	Regulatory Appendix15.1	3.5 (b) 3.14 3.18	
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.	Met. The Regulatory Requirement Appendix of the Provider Agreement (item 3.7 and 5.1) meets this requirement.	Regulatory Appendix 15.1	3.7 5.1	
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.	Met. The Fraud and Abuse Prevention and Detection P/P (p.5) demonstrates that the plan is aware of its responsibility to report providers who were denied credentialing or disenrolled for program integrity reasons immediately.	Fraud and Abuse Prevention and Detection 15.1 UnitedHealthcare Credentialing Plan 14.5	Detection and reporting 3.6	
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	Met. The Fraud and Abuse Prevention and Detection P/P (p.7)	P&P Fraud and Abuse Prevention and Detection	External Reporting	

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	MCO shall report overpayments made by DHH to the MCO as well as overpayments made by the MCO to a provider and/or subcontractor.	states, "The Health Plan will report to DHH overpayments made to the Health Plan, as well as overpayments made by the Health Plan to providers and contractors."	15.1		
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.	Met. Page 4 of the Fraud and Abuse Prevention and Detection P/P states "We will have at least one (1) full-time fraud, waste and abuse investigator physically located in the state for every 100,000 members, or fraction thereof."	P&P Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
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.	Met. The plan submitted a copy of their Government Programs Anti-FWA Program and their Corporate Responsibility and Compliance Program, which address this requirement.	FWA Plan Section A 15.2	Entire Document	
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.	Met. The plan submitted a copy of their Compliance Committee Charter. The charter details the committee's objective, which is to "is to assist the Plan Compliance Officer and Plan President in fulfilling their responsibilities of developing, implementing, and monitoring the Louisiana Compliance Program" and contains sections on committee membership, review process, roles and responsibilities, committee structure and operations. Larry Smith is the current Contract Compliance Officer and also the Organization Compliance Officer.	FWA Plan Section A 15.2 Compliance Committee Charter 15-2 Section B	 Entire Document	
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:	Met. The Fraud and Abuse Prevention P/P (p.2) contains this contract language.	FWA Plan Section A 15.2		
15.2.3.1	Written policies, procedures, and standards of	Met.			

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	conduct that articulate MCO's commitment to comply with all applicable federal and state standards;	The Government Programs Anti-FWA Program and UnitedHealth Group Code of Conduct both meet this requirement fully.	FWA Plan Section A 15.2		
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;	Met. The Government Programs Anti-FWA Program (Section 11, p.23) contains a section on Effective Communications/Fraud, Waste and Abuse Reporting, which gives examples of UHC Government Programs reporting mechanisms and communication channels. Page 1 of the Fraud and Abuse Prevention and Detection P/P describes the consequences if FWA is discovered within UHCCS and providers. UHCCS employees receive fraud and abuse awareness training as required by regulation, law, or contract or by company policy. Annual Fraud and Abuse Training is required by UnitedHealth Group and is delivered via LearnSource®, which is an on-line training program. Chapter 14 of the Provider Manual contains the section on Corporate Compliance – Fraud and Abuse.	FWA Plan Section A 15.2		
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;	Met. The Government Programs Corporate Responsibility and Compliance Program (p.7) contains a section on Auditing and Monitoring, which describes which departments are responsible for auditing and monitoring activities and an outline of how some of these activities might be conducted.	FWA Plan Section A 15.2		
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 fraud so that such reports cannot be diverted by supervisors or other personnel;	Met. The Government Programs Anti-FWA Program (Section 11, p.23) contains a section on Effective Communications/Fraud, Waste and Abuse Reporting, which gives examples of UHC Government Programs reporting mechanisms and communication channels. UHC's Code of Conduct document contains has a section (p.5) on "Who to Contact with Questions or Concerns", which provides employees with instructions when faced with a potential ethical issue. The contact information for the HR	FWA Plan Section A 15.2		

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		department, Compliance & Ethics Help Center, Compliance & Ethics, Government Relations Compliance Group, Risk Management is listed on this page.			
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);	Met. The Prospective FWA Investigations and Payment Prevention section in the Government Programs Anti-FWA Program includes a list of ongoing activities performed by UHC to audit and monitor FWA, for example – 1) Pre-payment data analytics 2) Post-payment data analytics 3) Billing analysis 4) Provider/member verification 5) Provider audits	FWA Plan Section A 15.2		
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.	Met. Page 4 of the Code of Conduct document states, "You have the option of reporting anonymously, where permitted by law, and, regardless of how you report, you are protected from retaliation whenever you speak up in good faith." The Fraud and Abuse Prevention and Detection P/P (p.4) states, "No individual who reports Health Plan violations or suspected fraud and abuse shall be retaliated against. To the extent possible, the identity of the reporting individual will be kept confidential. Anyone who believes they have been retaliated against can report it to DHH or the U.S. Office of Inspector General."	FWA Plan Section A 15.2		
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);	Met. Optum's Handling Suspect Tips and Referral – Triage Process P/P ensures all tips and referral are triaged and assigned within 2 business days. The Fraud and Abuse Prevention and Detection P/P demonstrates that the plan policies, procedures and internal controls in each functional area are designed to create an environment to deter and detect fraudulent or abusive conduct in a timely manner.	FWA Plan Section A 15.2		
15.2.3.8	Well-publicized disciplinary procedures that shall apply to employees who violate the MCO compliance program;	Met. The Code of Conduct document meets this requirement fully.	FWA Plan Section A 15.2		

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
		According to the Government Programs Corporate Responsibility and Compliance Program (p.7), disciplinary guidelines are publicized via the Code of Conduct, the UHC Compliance Program, the Employee Handbook, and company's eGRC Policy Center, and through communication methods such as company training, intranet sites, and newsletters.			
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;	Met. The Government Programs Corporate Responsibility and Compliance Program (p.4) contains a section on Effective Training and Education, which states that the plan maintains a new employee orientation that ensures compliance obligation awareness and provides tools for all employees to understand and follow the code and business practice expectations. In addition to new employee training, the plan provides mandatory annual employee compliance training including but not limited to FWA and Code of Conduct.	FWA Plan Section A 15.2 Provider Handbook 10.4 Member Handbook 12.12		 Pg. 62 Pg. 53
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.	Met. The Government Programs Corporate Responsibility and Compliance Program (p.4) contains a section on Effective Training and Education, which states that the plan maintains a new employee orientation that ensures compliance obligation awareness and provides tools for all employees to understand and follow the code and business practice expectations. In addition to new employee training, the plan provides mandatory annual employee compliance training including FWA. The Compliance Training Curriculum notes that compliance training modules such as Code of Conduct and FWA must be completed within 30 days of hiring date.	FWA Plan Section A 15.2		
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	Met. The Compliance Training Curriculum for new hires includes all the training modules listed in this contract requirement (and more) for completion within 30 days of hiring date.	FWA Plan Section A 15.2		

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	• Procedures for timely consistent exchange of information and collaboration with DHH; • 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.	Met. The Employee Background Checks P/P and Optum's Provider Sanctions and Monitoring P/P demonstrate that the plan screens 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 The plan submitted the template of their Monthly Sanction Checks Attestation signed by the Program Integrity Officer. This demonstrates that the plan conducts a monthly search of the websites listed in this contract requirement including the Louisiana State Board of Medical Examiners.	Optum P&P Provider Sanctions and Monitoring 15.3 UnitedHealthcare Background Checks 15.3 Disclosure Form Provider 15.1 Regulatory Appendix	Entire Document Entire Document Entire Document 3.11	

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
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	Met. Optum's Provider Sanctions and Monitoring P/P (p.5) contains a list of Sanctions Provider Data Sources, which includes the data sources specified in this contract requirement. The plan submitted the template of their Monthly Sanction Checks Attestation signed by the Program Integrity Officer. This demonstrates that the plan conducts a monthly search of the websites listed in this contract requirement including the Louisiana State Board of Medical Examiners.	Optum P&P Provider Sanctions and Monitoring 15.3	3.3 "state sources"	
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).	Met. Optum's Provider Sanctions and Monitoring P/P demonstrates that the plan has a process for monitoring provider sanctions across data sources on a monthly basis, for all UnitedHealth Group business segments. In the Fraud and Abuse Prevention and Detection P/P (p.5), the plan acknowledges that exclusions have to be reported to the DHH within 3 business days. The plan submitted the template of their Monthly Sanction Checks Attestation signed by the Program Integrity Officer. This demonstrates that the plan conducts a monthly search of the websites listed in this contract requirement including the Louisiana State Board of Medical Examiners.	Optum P&P Provider Sanctions and Monitoring 15.3 P&P Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	
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	Met. This contract requirement is addressed fully in the Provider Disclosures P/P, Attachment A: Disclosure of Ownership and Control Interest Statement.	P&P Fraud and Abuse Prevention and Detection 15.1	Detection and Reporting	

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	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.		Regulatory Appendix Disclosure Form	3.11	
15.3.4.2	The MCO shall notify DHH within three (3) 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.	Met. In the Fraud and Abuse Prevention and Detection P/P (p.5), the plan acknowledges that "Action against UHCCP" have to be reported to the DHH within 3 business days.	P&P Fraud and Abuse Prevention and Detection 15.1	External Reporting	
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	Met. The Fraud and Abuse Prevention P/P (p.6) contains this contract language.	Regulatory Appendix 15.1 UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program 15.2 - B	3.11	Pg. 16
15.4.2	The MCO is responsible for the return of any money paid for services provided by an excluded provider.	Met. The Fraud and Abuse Prevention and Detection P/P (p.7) states, "The Health Plan is responsible for the return of payments made to an excluded provider."	P&P Fraud and Abuse Prevention and Detection 15.1	External Reporting	
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	Met. Page 6 and 7of the Fraud and Abuse Prevention and Detection P/P contains this contract language.	P&P Fraud and Abuse Prevention and Detection 15.1	External Reporting	

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	(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.				
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);	Met. Page 6 of the Fraud and Abuse Prevention and Detection P/P contains the exact language as stated in this contract requirement.	P&P Fraud and Abuse Prevention and Detection	External Reporting	
15.5.2.2	Number of complaints reported to the Program Integrity Officer; and	Met. Page 6 of the Fraud and Abuse Prevention and Detection P/P contains the exact language as stated in this contract requirement.	P&P Fraud and Abuse Prevention and Detection	External Reporting	
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.	Met. Page 6 of the Fraud and Abuse Prevention and Detection P/P contains the exact language as stated in this contract requirement. A sample of the report of Investigative Complaints was submitted for review. All the data elements listed in this contract requirement was included in the report.	P&P Fraud and Abuse Prevention and Detection Report Template 145	External Reporting	
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.	Met. Page 7 of the Fraud and Abuse Prevention and Detection P/P states, "The Program Integrity Officer will attest monthly that a search of required websites has been completed to capture all exclusions."	P&P Fraud and Abuse Prevention and Detection Attestation Form	External Reporting	

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		A sample of the Attestation of Monthly Sanction Checks was submitted as evidence which demonstrates that the plan conducts a search of websites references in 15.3.3.			
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:	Met. In the 2015 QI Program Description (p.23), the plan describes QI program activities including the Ambulatory Medical Record Review, which evaluates: – The structural integrity of the medical record. – Documentation for the presence of information that conforms to standards of good medical practice, which includes evidence of continuity and coordination of care. – Presence of medical record confidentiality policies. – Advanced Directives The Provider Handbook contains a section on Charting Standards, which they require all participating PCPs to follow. UHC also submitted a copy of the audit tool, which is used during the audits.	NQM – 025 Ambulatory Medical Record Review P&P 14.5 Audit Tool Master 14.5	Entire Document Entire Document	
15.6.1.1	Accurate and legible;	Met. The audit tool, which is used during the onsite Medical Record Review, includes a check for "1. The medical record is legible.*"	NQM – 025 Ambulatory Medical Record Review P&P 14.5		
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	Met. The audit tool includes checks for: "8. Medical records are stored in an organized fashion for easy retrieval 9. Medical records are available to the treating practitioner where the member generally receives care 10. Medical records are released to entities as designated consistent with federal regulations 11. Records are stored in a secure location only accessible by authorized personnel"	NQM – 025 Ambulatory Medical Record Review P&P 14.5		
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and	Met. The audit tool includes a check for:	NQM – 025 Ambulatory Medical Record Review P&P		

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	Utilization Management review.	"10. Medical records are released to entities as designated consistent with federal regulations"	14.5		
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	N/A	NQM – 025 Ambulatory Medical Record Review P&P 14.5		
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	Met: The audit tool includes checks for: 3. Member identifying information is located on each page of the medical record. The name and credentials of provider rendering the services (e.g., MD, DO, OD, NP, PA) are documented." 4. Medical records contain pertinent patient demographic information including name, identification number, date of birth, sex and legal guardianship (if applicable); The beginning and ending times of the visit are documented." For #3, it is recommended that "Member identifying information is located on each page of the medical record" and "The name and credentials of provider rendering the services (e.g., MD, DO, OD, NP, PA) are documented" are separated into two separate elements. For #4, it is recommended that "Medical records contain pertinent patient demographic information including name, identification number, date of birth, sex and legal guardianship (if applicable)" and "The begin and end times of the visit are documented" are separated into two separate elements. In addition, for #4, It is recommended that "name", "identification number", "date of birth", "sex" and "legal guardianship" should be separate elements in the audit tool.	Audit Tool Master 14.5		
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Met. The audit tool includes a check for: "5. Medical record identifies primary language spoken and any cultural or religious preferences if applicable"	Audit Tool Master 14.5		
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	Met. These elements were included in the medical record audit	Audit Tool Master		

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		tool.	14.5		
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;	Met. These elements were included in the medical record audit tool.	Audit Tool Master 14.5		
15.6.2.5	Referrals including follow-up and outcome of referrals;	Met. The audit tool include checks for: "7. Evidence of tracking and referral of age and gender appropriate preventive health services 6. Appropriate use of referrals/consults, studies, tests"	Audit Tool Master 14.5		
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Met. The audit tool includes a check for: "14. Copies of hospital discharge summaries, home health care reports, emergency room care physical or other therapies as ordered by the practitioner are documented."	Audit Tool Master 14.5		
15.6.2.7	Signed and dated consent forms (as applicable);	Met. The audit tool includes a check for: "5. Signed and dated consent forms (as applicable); "	Audit Tool Master 14.5		
15.6.2.8	Documentation of immunization status;	Met. The audit tool includes a check for: "1. Evidence of current age appropriate immunizations"	Audit Tool Master 14.5		
15.6.2.9	Documentation of advance directives, as appropriate;	Met. The audit tool includes a check for: "6. Adults 18 and older, emancipated minors, and minors with children have an executed advance directive in a prominent part of the medical record. "	Audit Tool Master 14.5		
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.	Met. These elements were included in the medical record audit tool.	Audit Tool Master 14.5		
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history;	Met. These elements were included in the audit tool.	Audit Tool Master		

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	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.		14.5		
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	Met. . The Member Handbook (p.54) has been updated to state that members have the right to "Request and receive one free copy of his or her medical records, and request that they be amended or corrected."	Audit Tool Master 14.5		
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 administrative or judicial action brought by or on behalf of the state or federal government.	Met. Item 3.5 of the Provider Agreement Appendix requires providers to retain records of Covered Persons for six (6) years after the last payment was made for services provided to the Covered Person.	Regulatory Appendix 15.1	3.5 (c)	
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.	Met. While UHC has not explicitly included this contract language in any of documents, FWA P/Ps and Ant-FWA Program documents demonstrate the plan is proactive in investigating possible acts of FWA among its provider network and subcontractors.	Right of Recovery P&P 15.7	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	Met. Page 1 of the Right of Recover P/P the states, "1.Optum must initiate a complex review to determine a potential overpayment and/or underpayment within 365 days from the original date of service of a claim. a. Optum must deliver notice to the provider in writing of initiation of such a review, EXCEPT in the following circumstances: b. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which has been identified and referred to the	Right of Recovery P&P 15.7	Entire Document	

Contract | RFP Reference	Contract Requirement Language	Review Determination	MCO Documentation Title(s)	MCO Policy/Procedure / Document Section(s)/ Number(s)	MCO Page Number(s)
	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.	Department, MFCU, or other appropriate law enforcement agency, unless approved by DHH."			
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 provider appeal or rebuttal process. The MCO shall 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.	Met. Page 1 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
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.	Met. Page 1 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
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	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	

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	State.				
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.	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
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.	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
15.7.8	DHH must notify the MCO of an identified 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.	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
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.	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
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	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	

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	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.				
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.	Met. Page 2 of the Right of Recover P/P contains this contract language.	Right of Recovery P&P 15.7	Entire Document	
	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 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.	Met. . The Fraud and Abuse Prevention P/P (p.6) contains this contract language.	Regulatory Appendix 15.1	3.11	
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	Met. The Employee Background Checks P/P meets this requirement fully.	UnitedHealthcare P&P Background Checks PE		

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	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.		Regulatory Appendix 15.1	3.11	
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].	Met. Page 7 of the Fraud and Abuse Prevention and Detection P/P states, "Annually, the Health Plan will provide to DHH the name, Social Security Number and date of birth of each Key Staff member."	P&P Fraud and Abuse Prevention and Detection 15.2 - B	External Reporting	
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 Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.	Met. The Fraud and Abuse Prevention P/P (p.6) contains this contract language.	Regulatory Appendix 15.1 Optum P&P Provider Sanctions Monitoring	3.11 3.0	
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.	Met. The Fraud and Abuse Prevention P/P (p.6) contains this contract language.	Regulatory Appendix 15.1	3.11	
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the	Met. In page 16 of the Prospective FWA Investigations and			

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	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).	Payment Prevention section in the Government Programs Anti-FWA Program, the plan included Verification of Excluded Individuals and Entities as one of the activities they perform to prevent payments to suspended or excluded providers.	UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program FWA 15.2 - B Optum Provider Sanctions Monitoring P&P Additional PE	 Entire Document	Pg. 17
17.2.6.19	**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	Met. UHC's Prospective FWA Investigations and Payment Prevention section in the Government Programs Anti-FWA Program (p.15) ensures that their systems only 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.	UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program FWA 15.2 - B Disclosure Form 15.1		Pg. 17
18.1	Federal laws require full disclosure of ownership, management, and control of 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.	Met. The plan submitted a copy of the Ownership and Disclosure Form. However, there is no P/P that ensures that ensures that the form is 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.	Medicaid Ownership and Disclosure Form PE Folder 18.1	Entire Document	
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)	Met. The Fraud and Abuse Prevention P/P (p.10) contains this contract language.	Major Subcontractor list from RFP PE Folder 18.2		

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	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.				
18.3	**Report of Transactions with Parties in Interest -** 18.2.5 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 SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.2.6 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. 18.2.7 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. 18.2.8 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.	Met. The Fraud and Abuse Prevention P/P (p.11) contains this contract language.	Not Applicable.		

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	18.2.9 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.				
18.5	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.	Met. The Fraud and Abuse Prevention P/P (p.6) contains this contract language.	Disclosure Form 15.1 Optum Provider Sanctions Monitoring P&P Additional PE folder 18.5 Fraud and Abuse Prevention and Detection P&P 15.1	Entire Document External Reporting	
25.11	**Debarment, Suspension, Exclusion -** 25.11.1 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 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 . 25.11.2 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	Met. According to UHC's Employee Background Check Policy, "UnitedHealth Group conducts sanction and debarment checks on employees on a monthly basis or as deemed necessary. If an individual is sanctioned by the General Services Administration (GSA) or the Office of Inspection General (OIG), or if an individual is debarred from participating in any federal or state program, it may result in a review of responsibilities and consequences up to and including termination of employment." The plan submitted the template of their Monthly Sanction Checks Attestation signed by the Program Integrity Officer. This demonstrates that the plan conducts a monthly search of the websites listed in this contract requirement including the Louisiana State Board of Medical Examiners. The Provider Sanctions Monitoring P/P provide to outline the process involved for monitoring provider sanctions on a monthly basis, for UnitedHealth Group business segments.	Employee Background Checks P&P 15.1 Employee Sanctions Checks P&P 15.1 Disclosure Form 15.1 Regulatory Appendix 15.1 UnitedHealthcare Government Programs Anti-Fraud, Waste and Abuse Program 15.2 - B Employee Sanctions Monitoring P&P 15.1 Optum Provider Sanctions Monitoring P&P 15.3	Entire Document Entire Document Entire Document 3.11, 3.22 Pg. 16 Entire Document Entire Document	Pg. 16

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	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).				
25.39	**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; 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.	Met. The Fraud and Abuse Prevention P/P (p.10) contains this contract language.	Non-Covered Codes P&P PE Folder 25.39	Entire Document	