Healthy Blue of Louisiana

2019 Compliance Audit

Review Period: April 01, 2018 – March 31, 2019

Final Report Issued December 2019

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

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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. Further, 42 CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. 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. The 2019 annual compliance audit was a full audit of the MCO's compliance with contractual requirements during the period of April 1, 2018 through March 31, 2019.

This report presents IPRO's findings of the 2019 annual compliance audit for Healthy Blue of Louisiana (Healthy Blue).

Audit Overview

The purpose of the audit was to assess Healthy Blue'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 Healthy Blue's policies, procedures, files, and other materials corresponding to the following nine contractual domains:

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

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

Specifically, file review consisted of the following six areas:

1. Member Grievances
2. Appeals
3. Informal Reconsiderations
4. Case Management (behavioral and physical health)
5. Credential/Recredentialing
6. Utilization Management

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

Table 1: File Review Sample Sizes

File Type	Sample Size
Member Grievances	15
Appeals	10
Informal Reconsiderations	5
Case Management (physical health)	10
Case Management(behavioral health)	10
Credential/Recredentialing	10
Utilization Management	10

The period of review was April 1, 2018 through March 31, 2019. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "Not Applicable" 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 is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not Applicable	The requirement was not applicable to the MCO.

The 2019 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 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 April 2019. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the MCO in April 2019 in advance of the onsite audit.

Once LDH approved the methodology, IPRO sent Healthy Blue 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 File Transfer Protocol (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 two weeks 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 experienced IPRO auditors was convened to review the MCO's policies, procedures, and materials, and to assess the MCO's 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-day onsite visit, which included a review of elements in each of the nine review tools that were considered less than fully compliant based upon pre-onsite review, as well as file review.

The IPRO audit team visited Healthy Blue on July 8 and 9, 2019, 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 to allow the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy in accordance to state standards. MCO staff was given two days from the close of the onsite review to provide any further documentation.

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 MCO is compliant with the standard or a rationale for why the MCO was not compliant and what evidence was lacking. For each element that was deemed not fully compliant, IPRO provided a recommendation for the MCO to consider in order for them to attain full compliance.

Each draft report underwent a second level of review by IPRO staff members who were 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 provide responses for all elements that were determined to be less than fully compliant. The MCO was given one week to respond to the issues noted on the draft reports.

After receiving the MCO's response, IPRO re-reviewed each element for which the MCO provided a response. As necessary, review scores were updated based on the response of the MCO.

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	Non-compliance	N/A	% Full[1]
Core Benefits and Services	115	109	3	0	0	3	97%
Provider Network Requirements	184	168	16	0	0	0	91%
Utilization Management	87	87	0	0	0	0	100%
Eligibility, Enrollment, and Disenrollment	13	11	2	0	0	0	85%
Marketing and Member Education	83	82	1	0	0	0	99%
Member Grievance and Appeals	65	58	7	0	0	0	89%
Quality Management	114	109	3	0	0	2	97%
Fraud, Abuse, and Waste Prevention	118	88	15	15	0	0	75%
Reporting	1	1	0	0	0	0	100%
TOTAL	**780**	**713**	**47**	**15**	**0**	**5**	**92%**

[1] N/As are not included in the calculation.

As presented in **Table 3**, 780 elements were reviewed for compliance. Of the 780, 713 were determined to fully meet the regulations, while 47 substantially met the regulations, 15 minimally met the regulations and none were determined to be non-compliant. Five elements were "not applicable." The overall compliance score for Healthy Blue was 92% elements in full compliance.

IPRO extracted from each of the nine detailed reports those elements for which the MCO was found to be less than fully compliant. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, the MCO's initial response, and, when possible, suggestions to achieve full compliance.

It is the expectation of both IPRO and the LDH that Healthy Blue submit a corrective action plan for each of the 62 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that Healthy Blue may have implemented corrective actions for some areas identified for improvement while the audit was in progress, but these corrective actions will still require a written response since they were made after the period of review. Almost all of the review domains, with the exception of Reporting and Utilization management domains revealed at least one citation for compliance. Notably, there were 15 elements in the Fraud, Abuse, and Waste Prevention domain which received a determination of "minimally compliant" and should receive significant attention by the MCO to ensure that they meet compliance for this important regulatory area.

Each of the nine review tools and review determinations for each of the elements follow **Table 4**. Note that the yellow highlighting in the element descriptions reflects new language in the state regulations that was added since the 2016 compliance review period.

Table 4: Deficient 2019 Audit Elements

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Core Benefits and Services					
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 developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager. The individualized treatment plans must be:	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review	Substantial	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5 and in the 2019 CM Program Description on page 24. **File Review Results** Of the 10 case management files reviewed, 10 had a care plan, including the 8 identified as having special needs. Ten (10) of 10 care plans were developed with member and/or family involvement. Ten (10) of 10 members had care plans with short- and long-term goals. Of the 10 behavioral health case management files reviewed, the requirement for a plan of care based on the needs assessment was applicable to 8 members. There were 2 members without a plan of care for whom the individualized plan of care requirement was deemed not applicable—the first due to multiple unsuccessful member contact attempts and the second due to CSoC enrollment. However, the case management record documented care planning that included member demographics, member goals, supports and services, and a plan for addressing crisis/preventing unnecessary hospitalizations for 10 of 10 files reviewed. Of 8 applicable files, 7 met the requirement for an individualized plan of	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				care based on the needs assessment. The one member who did not meet the individualized care plan requirement did have a care plan; however, the care plan addressed the behavioral health diagnosis, but not the type 1 diabetes diagnosis. The care coordination notes did address ongoing interventions to address the diabetes diagnosis, including PCP visits; however, care coordination notes also documented a HEDIS alert HbA1c >9 pending without follow-up, and this young adult member expired in the hospital due to complications of type 1 diabetes. **Recommendation** There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses physical health, as well as behavioral health. In addition, an enhanced process for sharing the plan of care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, including timely follow-up on HEDIS alerts, such as the HbA1C >9. **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case	

Deficient 2019 Audit Elements					
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				management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing the plan of care as recommended.	
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	P/P Individual Treatment Plans Plan of Care Includes Case Management File Review	Substantial	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5, and implementation is supported by the Care Plan document. **File Review Results** Of the 10 case management files for members with care plans, 2 were unable to be contacted by CM for follow-up due to multiple unsuccessful contacts. Of the 8 applicable files, 8 met the requirement for ongoing review and revision as indicated. The requirement for monitoring of outcomes was applicable to 9 of the 10 behavioral health case management files, as 1 was excluded due to multiple unsuccessful outreach attempts. Although the requirement for a care plan was deemed not applicable for the 1 member enrolled in CSoC, ongoing monitoring of outcomes was documented for this member in the care	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				coordination notes. Nine (9) of the 9 files met the requirement for monitoring of outcomes. Seven (7) of 8 applicable files met the requirement for revision of the treatment plan as necessary. The 1 file that did not meet this requirement did document revision of the care plan for the behavioral health diagnosis, but not for diabetes; consequently, the care plan was not revised to address the HEDIS alert HbA1c > 9 and care coordination notes indicated that status for this alert was pending. **Recommendation** There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses ongoing monitoring of both physical health and behavioral health, with revisions made to address changing physical health and behavioral health needs. In addition, an enhanced process for sharing the plan of care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, particularly timely follow-up on HEDIS alerts, such as the HbA1C > 9. **Final Review Determination** No change in determination. IPRO reviewed the case management	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing and revising the plan of care on an ongoing basis as recommended.	
6.28.2.3	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 for members requiring behavioral health services.	CM records P/P for care coordination Includes Care Management File Review	Substantial	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 8, and the Coordination of Care — LA Policy and Procedure addresses face-to-face engagement for high-risk members or otherwise difficult to reach on page 5, as well as in the Case Management Face-to-Face Intervention-LA Policy and Procedure. **File Review Results** Of the 10 files reviewed, 1 was not applicable due to multiple unsuccessful attempts to contact the member. Of the 9 applicable files, 9 met the general care coordination requirement, including the 8 identified as having special needs. Eight (8) files documented indications for referral, and 8 referrals were made. Of the 9 applicable files, there were 4	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				with BH diagnoses, and all 4 received care coordination that integrated BH with PH health. Of the 9 applicable files, there were 7 members for whom coordination with the Chronic Care Management Program was applicable and, of these 7, 6 met this requirement. The 1 file that did not meet this requirement was a high-risk pregnancy case with chronic disease other than hypertension/preeclampsia currently monitored as a Prematurity Extension PIP Intervention Tracking Measure (ITM). Of the 10 behavioral health case management files, 10 met the requirements for care coordination, release of information to coordinate with the PCP, and for referrals as indicated. Coordination with the Chronic Care Management Program was applicable to 8 of the 10 files, and 8 of 8 met this requirement. **Recommendation** The MCO should enhance and monitor care management for high-risk pregnant women with chronic physical conditions, not limited to hypertension/preeclampsia. **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and	

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) sending an education document is a passive, not a robust intervention, and (3) the MCO did not detail actions taken to develop and implement an enhanced process for care management as recommended.	
Provider Network Requirements					
7.1.7	The MCO's network providers shall ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Provider Network P/P for Access and Availability	Substantial	This requirement is partially addressed in the Model Facility Agreement, Physician and Ancillary agreements that discuss the cultural competency requirements. However, this language should be included in the provider manual also. **Recommendation** The MCO should include language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities in the provider manual.	Healthy Blue will add language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities to the provider manual. The next round of provider manual updates will take place this fall, with an updated manual being made available to providers in January 2020.
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	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Substantial	Although this requirement is addressed in the provider manual on page 14, the language in the member handbook does not fully address this requirement. Page 12 of the member handbook states that new members follow the timelines listed in the requirement, but not current members identified as pregnant within the first or second trimester. This was discussed on-site with the provider network management staff and it was clarified that the policy applies to both	Healthy Blue will update language in the member handbook to show the requirement timeline addresses both new and current members newly identified as pregnant. The next round of member handbook updates will be completed by Q4 2019.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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;			new and existing members as written in the provider agreement and is addressed with providers in the provider manual. **Recommendation** The MCO should update the language in the member handbook to show the requirement timeline addresses both new and current members newly identified as pregnant.	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is referenced in the Provider Network Development Plan. In review of the 220 HBL Report, distance requirements are met for all rural parishes, but not for all urban parishes for both adult and adolescent primary care providers. **Recommendation** The MCO should improve access to PCPs for their urban members.	As of July 2019 Adult Urban access is 97.8% and Pediatric Urban access is 98.4%; The Network team is working currently working with 3 large urban PCP groups to be added to our Network. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
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 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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is referenced in the Provider Network Development Plan. The MCO provided 220 HBL Reports. The Q4 2018 report indicates that distance requirements are mostly met for rural parishes, but they are not met for all urban parishes. **Recommendation** The MCO should improve access to hospitals for their urban members.	HBL currently has ALL acute care hospitals located in the state under contract.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	living in urban parishes shall not exceed 10 miles.			**Final Review Determination** No change in review determination. As per the language of the contract, it states that travel distance shall not exceed 10 miles for all urban members. There may be a lack of hospitals in certain areas, which can pose as a limitation to the MCO meeting this requirement.	
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 the Provider Network Companion Guide.. LDH 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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is referenced in the Provider Network Development Plan in Access to Specialists. In review of the 220 HBL reports, all the MCO's specialties (except ob/gyn) meet the access standard for accessibility within 90 miles. All specialties (except ob/ gyn) meet the requirement that at least 75% of members have access to the specialty in a 60-mile distance, and all members have access to specialists within 90 miles. As listed in the Provider Network Development Plan, access to ob/gyns should not exceed 30 miles in rural parishes and shall not exceed 15 miles in urban parishes. Not all urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to ob/gyns for their rural and urban members.	Currently HBL as 96.4% Urban and 95.4% rural access for OBGYN; Many Parishes in Louisiana do not have Hospitals and/or Hospitals that offer OB Services. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	be approved by LDH for this purpose.				
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 and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is not referenced in the Provider Network Development Plan. In review of the 220 HBL Geo Access Report, all key geographic urban and rural areas meet the standard for accessibility. Most, but not all, of the other urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to lab services for all rural and urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language.	Overall, HBL has 98.9% urban and 99.9% rural lab access; Network will target these area to improve access; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1 Travel distance shall not exceed 10 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is not referenced in the Provider Network Development. The Q4 2018 Reports indicate that distance requirements are met for rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language.	Overall, HBL has 98.3% urban and 100% Rural access. Network will work with our PBM to improve access in needed areas; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1 Travel distance shall not exceed 10 miles in urban areas; and .2 Travel distance shall not	Network Provider Development and Management Plan P/P for Access and Availability	Substantial	This requirement is not referenced in the Provider Network Development Plan. Most, but not all, urban and rural parishes meet the access standard for hemodialysis centers.	Overall, HBL 90.1% urban and 98.4% rural; The state has a limited number of these facilities and will work to improve the network.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	exceed 30 miles in rural areas.	GeoAccess reports Requests for exceptions		**Recommendation** The MCO should improve access to pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the requirement language.	The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is referenced in the Provider Network Development Plan, and 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for behavioral health specialists and psychiatrists are met for rural parishes and mostly met for urban parishes. **Recommendations** The MCO should improve access to behavioral health specialists for all urban members.	Overall HBL has a 98.9% urban access for BH Specialists and will continue to improve access by contracting any available BH Specialists.
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	The requirement language is missing from the Provider Network Development Plan. 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for inpatient psychiatric hospitals are met for rural parishes and urban parishes. **Recommendation** The MCO should include the requirement language in the Provider Network Development Plan. **Final Review Determination** No change in review determination. It is understood the MCO follows the Provider Network Companion guide but	The health plan follows requirements of the Provider Network Companion Guide.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				the language should be included in the Provider Network Development Plan (as seen for the other provider type standards).	
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	P/P for Provider Network P/P for Provider Termination Sample notice to providers Sample notice to LDH	Substantial	In the Provider Network Development Plan, on page 24, it states that the MCO will provide immediate notification to the provider and notify LDH of the termination after the written notification to the provider soon after, but no later than 7 calendar days. This is not in line with current requirement language. However, the provider termination process was discussed on-site with staff, who stated that termination notices are sent out immediately or as soon as a decision has been reached on a provider's status and LDH has been informed of providers that should be terminated for cause. A sample provider termination letter was provided after the on-site. A sample email to LDH notifying them of all provider termination letters was also provided. Additionally, the standard Report 145 HBL lists the names of providers who are terminated for cause. **Recommendation** The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language. **Final Review Determination** No change in review determination. Based on the response provided by	Timely Notification of Participating Provider Termination policy, #4 Page 6 of 8

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.	
7.6.3.6	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 care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	P/P for Provider Network P/P for Provider Termination Sample notice to members Member Handbook	Substantial	The requirement language is partially addressed in the Timely Notification of Participating Provider Termination Policy. As discussed at the on-site audit, termination processes and member notifications are coordinated simultaneously. **Recommendation** The MCO should update the Timely Notification of Participating Provider Termination Policy to include the criterion of MCO members who have received care "within the past two years." **Final Review Determination** No change in review determination. Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that	Timely Notification of Participating Provider Termination – LA; # a Page 6

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.	
7.7.1	LDH considers mainstreaming of MCO 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.	Provider contracts Provider Handbook/Manual	Substantial	This requirement is partially addressed in the provider manual on page 65. The meaning of the requirement is addressed on pages 14 and 15 that services should not be administered to members in any way different from the public or those providers should not show preference to other insured or private-pay patients. However, the provider contracts do tell providers that they must not discriminate members based on sex, race, creed, and other discriminating factors, such as a person's status as a program contract beneficiary. **Recommendation** The MCO should define mainstreaming appropriately within the Provider Manual as well as communicate mainstreaming requirements in their various provider contracts.	Healthy Blue will define mainstreaming appropriately within the Provider Manual. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.
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,	Provider contracts Provider Handbook/Manual Member Handbook	Substantial	The requirement is partially addressed in the provider contracts in the Non-discrimination. section. **Recommendation** The MCO should indicate in their provider contract(s) and provider manual that they will take affirmative action to mainstream and ensure members are provided covered services without	Healthy Blue will indicate in the provider manual that we will take affirmative action to mainstream and ensure members are provided covered services without discrimination. The next round of provider updates will take place this fall, with an updated provider manual

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:			discrimination.	being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.
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.	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports	Substantial	The requirement language is not in the Provider Network Development Plan. However, the Q2 2018 Geo Access Report indicates 95.8% of urban parish members have access to an ob/gyn in a 15-mile radius and 95.4% of rural parish members have access to an ob/gyn provider in a 30-mile radius. **Recommendation** The MCO should include this language in their Provider Network Development Plan. **Final Review Determination** No change in review determination. The rebuttal version of the Network Development Plan document, which was provided in response to our recommendation, is not the same documentation that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the document with the added language for the next audit review.	Network Development Plan, Section 7.8.3.3, page 30
7.8.15.5 7.8.15.5.1 7.8.15.5.2	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph	P/P provider network P/P care coordination Network reports	Substantial	The first bulleted requirement is communicated to members in the member handbook. The second bulleted requirement is not listed specifically in the Provider Network Development Plan.	Network Development Plan, Indian Health Care Providers (IHCPs), Page 35-36

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	42 CFR §438.14 (b)(1) if: .1 Indian members are permitted by the MCO to access out-of-state IHCPs; or .2 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).			**Recommendation** The MCO should add the language pertaining to timely access to IHCPs specifically addressed in the Provider Network Development Plan.	
Eligibility, Enrollment, and Disenrollment					
11.11.3.1	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 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 LDH is terminated; • Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access	P/P for Member Disenrollment	Substantial	This requirement is not fully communicated to members in the member handbook. Bullets 2, 4 and 7 were not specifically discussed in the handbook. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically bullets 2, 4 and 7, so members are clear on the reasons why they may disenroll from the MCO.	Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 LDH and/or its agent.				
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 LDH imposes the intermediate sanction provisions specified in 42 CFR	P/P for Member Disenrollment	Substantial	This requirement is partially addressed on pages 1 and 60 of the member handbook. Bullet 1 and 3 were addressed in the handbook, but bullets 2 and 4 are missing. It also does not state that members can disenroll "without cause" due to the listed items. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically make reference to bullets 2 and 4 and state these requirements do not require good cause..	Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	§438.702(a) (3).				
Marketing and Member Education					
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial	This requirement is partially addressed in the Provider Directories Policy and submission of the hard copy directory as well as the web link. However, website URLs and the providers cultural competency training are not included. **Recommendation** Healthy Blue should include both the website URL and the provider's cultural competency training in their directory. **Final Review Determination** No change in findings. While the website does contain the provider URL and cultural competency information when available, this requirement is for the hard copy directory which does not contain this information.	Healthy Blue includes the website URL (if the provider has one), as well as cultural competency training in the provider directory. (See evidence "Provider Directory Website_2")
Member Grievance and Appeals					
13.2.4.2	The member or provider may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited	P/P for Appeals P/P for Fair Hearing	Substantial	This requirement is partially addressed in the Member Appeals – Core Process LA Policy. **Recommendation**	Member Appeals – Core Process Policy page 2 of 16

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	resolution.			The MCO should finalize updated policy to include new language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	
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, the member's request will be deemed to exhaust the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.	P/P for Appeals	Substantial	This requirement is partially addressed in the Member Appeals—Core Process – LA Policy on page 4. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, number 5, page 4 of 16
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.	P/P for Appeals Includes Member Appeals file review	Substantial	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 3 and the member handbook, Grievances and Medical Appeals, on page 55. **Appeals File Review Results** Eight (8) of 10 appeals files reviewed were compliant. **Recommendation**	Staff training was conducted with ongoing monthly monitoring by internal accreditation staff.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				The MCO should ensure that appeals are resolved according to contractual requirements of 30 days.	
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. • Within two (2) calendar days 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. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeals File Review	Substantial	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 14. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Appeals File Review Results** Two (2) of 2 appeals files reviewed were compliant. Eight (8) files were NA. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, Extending Decision Timeframe, page 13-14 of 16
13.6.3	In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.	P/P for Appeals	Substantial	Member Appeals – Core Process – LA Policy on page 9. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination**	Member Appeals – Core Process Policy, number 5, page 4 of 16

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	
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 in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have exhausted the MCO's appeal process as of the date upon which a final determination should have been made.	P/P for Appeals	Substantial	This requirement is partially addressed in the Member Appeals –Core Process – LA Policy on page 4. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, number 5, page 4 of 16
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 but no later than 72 hours from the date it receives notice reversing the decision..	P&P for effectuation of reversed appeal resolutions	Substantial	This requirement is addressed in the Member Appeals – Core Process — LA Policy on page 13. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, Continuation of Benefits, page 12-13 of 16

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Quality Management					
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets	Substantial	This requirement is addressed in the Intervention Tracking Measure (ITM) Workgroup meeting notes for March 21, 2019, and in the Quality Meeting Participation document. The MCE submitted PDSA worksheets and run chart for all ITM workgroup meetings, except for the meeting on October 4, 2018, which the plan did not attend due to all PIP staff attending the NCQA Conference, with advance notice to IPRO and LDH on 9/20/18. **Recommendation** Healthy Blue should ensure that at least one representative is available to attend all PIP meetings, and submit all requested monitoring documentation for each meeting.	Healthy Blue will ensure that a representative is present at all IMT and QM meetings moving forward and documentation is submitted.
14.2.3.6	Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	QAPI program description	Substantial	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11 regarding data collection, and in the HEDIS Administration Process Policy and Procedure regarding HEDIS measures, as well as reliability for manual chart abstraction; however, the methods the plan uses to ensure data validity and reliability for Intervention Tracking Measures used for PDSA QI are not described. In response to EQRO request for documentation, the MCO submitted the 17-P Involan summary screen shot, which shows the logic for the retrospective annual 17-P measure but	Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				not for the concurrent monthly ITMs used to monitor CM outreach, engagement, and facilitation. On-site, the plan explained how the CM data used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **Recommendation** The MCO should continue with their plan to improve data integrity.	
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan	Substantial	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11, and the 17-P Inovalon summary screen shot presents the logic for the annual 17P performance measure, which is also supported by the HEDIS Administration Process policy on page 7; however, pertinent to contractual requirement 14.2.5.2, the similarity between the monthly ITM denominator to measure pregnant women with a prior preterm birth and the annual 17P denominator merits supporting documentation and explanation of the accuracy of these measures. On-site, the plan explained how the CM data used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **Recommendation** The MCO should continue with their plan to improve data integrity.	Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process.

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
Fraud, Abuse, and Waste Prevention					
15.1.3	The MCO and its subcontractors 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, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, 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 ten (10) years from the expiration date of the Contract (including any extensions to the Contract), or from the date of completion of any audit, whichever is later, 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. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special	FWA Compliance Plan	Substantial	This requirement is partially addressed within the March 2019 SIU Antifraud Plan. Missing from the language is the requirement addressing that regulatory agencies may have access to information regarding the quality, timeliness and appropriateness of services 10 years from the expiration of the Contract or from the date of any audit completion, whichever is later. Also missing from the language is that under special circumstances, MFCU will be allowed after-hours admission. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	circumstances determined by the MFCU when after-hour admission will be allowed.				
15.1.6	The MCO and its providers and subcontractors 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.	FWA Compliance Plan	Substantial	This requirement is partially addressed by the March 2019 SIU Antifraud Plan on page 28. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.8	The MCO and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	FWA Compliance Plan	Substantial	This requirement language is missing in the March 2019 SIU Antifraud Plan on page 26. However, LDH approval of any grievance procedures prior to implementation is discussed in the Member Complaints and Grievances document. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language.	Requirement will be added to the Anti-Fraud Plan.
15.1.9	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	FWA Compliance Plan	Substantial	The language is missing from the March 2019 SIU Antifraud plan. On pages 7 and 8 of the Program Integrity plan, cost avoidance integration with claims adjudication and cost containment activities are discussed. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	regulations, the Contract, and LDH policy.			with LDH. This can be presented at the next audit review.	
15.1.10	The MCO will report to LDH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated LDH Program Integrity contact.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms	Minimal	This requirement is not addressed in the March 2019 SIU Antifraud Plan. As discussed onsite, the MCO does ongoing monitoring of their provider network, employees and subcontractors. The MCO provided an Excluded Individuals and Entities policy. However, language concerning sending reports to LDH within a three day timeframe is missing in the provided documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language.	Language will be added to Anti-Fraud Plan.
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) 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-	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms	Minimal	The requirement is evidenced by the Provider Disclosure Form but the language is missing in the March 2019 SIU Antifraud Plan. As discussed onsite, disclosures are a part of the ongoing activities and credentialing processes overseen by the provider network. Disclosures are referenced in the provider agreement in section 6.23, but timeliness of routinely submitted disclosures is not addressed in any documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language.	Medicaid Subcontractors Disclosure of Ownership P&P – Full Document Credentialing Policies are to be revised to reflect all applicable timeframes.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.			**Final Review Determination** No change in determination. Although the documentation does satisfy the requirement and would be substantial evidence the MCO has policies in place that address this requirement, the Medicaid Subcontractors Disclosure of Ownership document was not provided for the pre-onsite review or the onsite follow-up documentation. Please provide this document to show compliance with the requirement for the next audit review period and please include language on the timeframes where applicable.	
15.1.15	LDH or its designee will notify the MCO when it 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:	FWA Compliance Plan	Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite. Language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. The MCO did confirm onsite that LDH approval is needed in order for recoupments or withholds to occur. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.15.1	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	FWA Compliance Plan	Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	or federal investigation and/or lawsuit, including but not limited to false claims act cases; or			recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan	Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.15.3	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.	FWA Compliance Plan	Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.1.16	The prohibition described above in Section 15.1.15 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 LDH.	FWA Compliance Plan	Minimal	This requirement is not addressed by the Program Integrity Plan nor the March 2019 SIU Antifraud Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.17	The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see 15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..	FWA Compliance Plan Payment Suspension P/P	Minimal	The language is missing from the March 2019 SIU Antifraud plan and is not addressed in the Program Integrity Plan. This requirement is minimally addressed by the Overpayments Policy. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence..	FWA Compliance Plan	Substantial	The language of the contract is not addressed in the March 2019 SIU Antifraud Plan but staff was able to speak to the investigative process onsite. Provider and Member Fraud Referral Forms were provided. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.18.5	When making a referral of suspected fraud, the MCO shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of this Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form	FWA Compliance Plan Provider referral forms	Substantial	The language of the contract is not addressed in the March 2019 SIU Antifraud Plan. MCO provided a Fraud Referral Template and a Fraud Notice Template that shows compliance with the requirement. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.7	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:	FWA Compliance Plan	Substantial	The language of the contract is partially addressed in the SIU Antifraud Plan and is partially addressed by the Investigations of Suspected Fraud and Abuse policy document. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan	Minimal	This requirement language, although referenced, is missing in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				Recommendation The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan	Substantial	This requirement language is partially addressed on page 25 in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	FWA Compliance Plan	Minimal	This requirement language is not listed in the SIU Antifraud Plan, however, SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.9	The MCO and its subcontractors 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,	FWA Compliance Plan	Substantial	The language is missing in the March 2019 SIU Antifraud Plan. MCO regularly meets with contracted vendors, and if vendors open a case, they notify the MCO so they can inform the state and a case is opened with the reporting vendor.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.			Discussed onsite, the Dental vendor does their own investigations. The MCO has the ability to make referrals to vendors and has the ability to mine their vendor's data. **Recommendation** The MCO should obtain approval for the updated SIU Anti fraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.18.10	The MCO and/or its subcontractors are 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.		Substantial	This requirement was discussed onsite. The MCO does not actively suspend payments to providers unless directed by the state. The Provider Garnishment Process does not meet compliance for this requirement as it pertains to Kentucky requirements. **Recommendation** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. **Final Review Determination** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana	Overpayments Policy – Full Document Provider Hold Process – Full Document Payment suspension policy is being created specific to LA

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
				should be developed.	
15.5.1	The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	FWA Compliance Plan	Minimal	This requirement was discussed onsite with staff, Although referenced on page A3, this requirement language is missing in the SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.2	The MCO and its subcontractors shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. The MCO shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status. 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 LDH.	FWA Compliance Plan	Substantial	This requirement is partially discussed in the Investigations of Suspected Fraud and Abuse document and overpayments are reported on the 145 Report. No documentation discussed the right to audit providers and members within a 5 year period. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.3	All reviews shall be completed within eight months (240	FWA Compliance Plan	Substantial	The language is missing in the SIU Antifraud Plan. This requirement was	Language has been added to the Anti-Fraud Plan and is

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.			discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	currently in review with LDH.
15.7.4	The MCO shall confer with LDH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by LDH.	FWA Compliance Plan	Substantial	This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. Post-payment is discussed in the Program Integrity Plan. This requirement was discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.5	Contact with the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law	FWA Compliance Plan	Minimal	This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. This requirement was addressed onsite by the MCO, but the language was not found in submitted documentation.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	enforcement agency, unless approved by LDH			**Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.7.7	LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. LDH may recover from the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.	FWA Compliance Plan	Minimal	This requirement language is partially addressed in the Overpayments Policy and is missing in the SIU Antifraud Plan although the requirement is referenced on page A3. Missing from all documentation was the requirement of the right to audit within a 5 year period from the date of service of a claim. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business	FWA Compliance Plan	Substantial	The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. An MCO Fraud Referral Template was provided to show evidence of compliance. Onsite, SIU unite confirmed they have a case tracking system. **Recommendation** The MCO should update the SIU Antifraud plan, which is in review with LDH, to include this requirement language.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Deficient 2019 Audit Elements					
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and reviewer instructions	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.				
15.7.10	In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.	FWA Compliance Plan	Minimal	The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. The 14 day timeliness of compliance with state requests is not written in any documentation. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.11	There will be no LDH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Medicaid Managed Care Contract period of for providers for which no MCO relationship existed.	FWA Compliance Plan	Minimal	The requirement language is missing in the March 2019 SIU Antifraud Plan. Recoupments were discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the	FWA Compliance Plan	Substantial	This requirement is not addressed by the Provider Garnishment Desktop Procedure as the provided document	Overpayments Policy – Full Document

Deficient 2019 Audit Elements					
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	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 LDH or its authorized agent(s).			pertains to Kentucky requirements, not Louisiana. **Recommendation** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. **Final Review Determination** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana should be developed.	Provider Hold Process – Full Document Payment suspension policy is being created specific to LA

MCO Final Audit Tools

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

Core Benefits and Services

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.4	**Behavioral Health Services**					
6.4.5 6.4.5.1	**Permanent Supportive Housing** LDH 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, Medicaid Managed Care 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 LDH and final approval for members to participate in PSH is made by the LDH 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;	Member letters Member handbook		Full	This requirement is addressed in the Behavioral Health – Permanent Supportive	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		P/P member education			Housing policy on page 4, and in the Healthy Blue Member Handbook on Page 28.	
6.4.5.1.2	Assist members in completing the PSH program application;	Member letters Member handbook P/P member education		Full	This requirement is addressed in the PSH Identification and Outreach Workflow document.	
6.4.5.1.3	Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	Communications to LDH P/P education		Full	This requirement is addressed in the 2018 CM Program Description on page 10 and in the 2019 CM Program Description on page 22.	
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and	Completed LDH template		Full	This requirement is addressed in the Q3 2018 Healthy Blue PSH Report and in the Q4 2018 Healthy Blue PSH submitted apps documents.	
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:					
6.4.5.2.1	Identify a PSH program liaison, to be approved by LDH, to work with LDH 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.	Organizational chart		Full	This requirement is addressed in the 2018 LA Plan Organization Chart.	
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.	Training slides P/P provider education Provider handbook		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy on page 7, the BLA-PM-0006-18 LA Medicaid Provider Manual Update_FINAL_no_cover posted on pages 12 and 65, and the BLAPEC-0804-19 New Provider Orientation Deck Update FINAL.	
6.4.9.1	The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk	Provider handbook Provider education materials Provider contracts P/P provider education		Full	This requirement is addressed in the BLA-PM-0006-18 LA Medicaid Provider Manual Update_Final_no_cover **on** pages 12, the BLAPEC-0804-19 New Provider Orientation Deck Update FINAL, and the mock scorecard screening info.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.					
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.	P/P provider education Provider handbook		Full	This requirement is addressed in the BLA-PM-0006-18 LA Medicaid Provider Manual Update_Final_no_cover on page 12, and in the reports 313 HBL 2018 Q2 and 313 HBL 2018.	
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 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.	P/P behavioral integration Communications with community agencies		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 7, the Behavioral Health Emergency Care Policy and Procedure on pages 2 and 3, the Safe Haven Presentation General 1.24.2018, The Living Room Proposal 9-7-18, the Meeting Invite – One TeleMed, and the Other Important Phone Numbers document excerpted from the member handbook.	
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,	Member handbook P/P ER services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services –	

Core Benefits and Services						
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	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.				Core Process – LA Policy and Procedure on pages 2-3, and in the Healthy Blue Member Handbook on pages 16 and 41.	
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.	Member handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 16 and 41.	
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.	Member handbook P/P Member services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 5 and in the Healthy Blue Member Handbook on page 16.	
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.	Member handbook P/P emergency services		Full	This requirement is addressed in the Behavioral Health Emergency Care Policy and Procedure on page 7 and is communicated to the member on page 31 of the Healthy Blue Member Handbook.	
6.8.1.5	The attending emergency physician, Licensed 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.	Provider handbook P/P Care coordination		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 3.	
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	P/P Coordination of services Communications to hospital		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 3.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.					
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 LDH 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.	P/P Coordination of Services Quality of core plan Member handbook		Full	This requirement is addressed in the 2018 QMC Eval_QMC on pages 43-44, the 2018 UM Program Description on page 40, and is communicated to the member in the ER Brochure LA 0917 on page 4.	
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member & provider handbook Educational materials		Full	This requirement is addressed in the BLA-PM-0006-18 LA Medicaid Provider Manual Update_Final_no_cover on page 69 and in the Healthy Blue Member Handbook on page 41.	
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 who possesses an average knowledge of health and medicine.	P./P Emergency services Member handbook		Full	This requirement is addressed in the 2019 UM Program Description on pages 44 and 49, the BLAPEC-0439-17 BHQIP 2018 Program Description FINAL on page 4, and in the mock scorecard screening info document.	
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	Member handbook		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on	

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	diagnose the specific condition or stabilize the patient.				page 3 and in the Behavioral Health Emergency Care on page 7, as well as in the Healthy Blue Member Handbook on page 41.	
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	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 3.	
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 3.	
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	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 3.	
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.	P./P post stabilization services Provider handbook		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on pages 3 and 4, as well as in the BLA-PM-006-18 LA Medicaid Provider Manual Update_Final_no_cover on page 30.	

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6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	P./P post stabilization services				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 4.	
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 4.	
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 4.	
6.8.2.2.4	The member is discharged.	P./P post stabilization services		Full	This requirement is addressed in the Emergency and Post-Stabilization Services – Core Process – LA Policy and Procedure on page 4.	
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 including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal					

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	abstinence syndrome (NAS) or fetal alcohol syndrome;					
6.19.1.4	Individuals with substance use disorders who have dependent children;					
6.19.1.5	Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;					
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;					
6.19.1.7	Adults, 18 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 or are transitioning out of the CSoC program.					
6.19.1.8	Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;					
6.19.1.9	Individuals with co-occurring behavioral health and developmental disabilities;					
6.19.1.10	Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;					
6.19.1.11	Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and					
6.19.1.12	Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.					
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). LDH may also identify special	HRA P/P members with Special Health Needs Documentation of		Full	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 4 and in the 2019 CM Program Description on page 24.	

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	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 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.	assessment conducted Includes Case Management File Review			**File Review Results** Of the 10 case management files reviewed, 10 documented diagnosis and 10 met the requirement to conduct an individual needs assessment within 90 days of identification and with 8 of 10 identified as members with special health care needs. Of the 10 behavioral health case management files reviewed, 10 documented diagnosis and 10 met the requirement to conduct an individual needs assessment. The requirement for a special health care needs (SHCN) plan of care was applicable to 8 members. There were 2 members without a SHCN plan of care for whom the plan of care requirement was deemed not applicable, the first due to multiple unsuccessful member contact attempts and the second due to Coordinated System of Care (CSoC) enrollment. The latter CSoC member was the only one for whom the CSoC review items were applicable, and this file met the requirement per documentation of CSoC enrollment. The requirement for contact with the Integrated Medicaid Managed Care Program plan care manager was applicable to 7 members, and 7 of 7 met this requirement.	
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: .1 The MCO shall utilize Medicaid historical claims data (if available) to identify members who	P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management		Full	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 4 and in the 2019 CM Program Description on page 24. The report Monthly_SHCN_Jan19 provides documentation to support implementation of this requirement.	

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and Reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	meet MCO, LDH approved, guidelines for SHCN criteria. .2 MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. .3 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. .4 Members may be identified by LDH and that information provided to the MCO.	File Review				
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 developed by the treating provider(s) and a person-centered plan of care developed by the MCO care manager. The individualized treatment plans must be:	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review		Substantial	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5 and in the 2019 CM Program Description on page 24. **File Review Results** Of the 10 case management files reviewed, 10 had a care plan, including the 8 identified as having special needs. Ten (10) of 10 care plans were developed with member and/or family involvement. Ten (10) of 10 members had care plans with short- and long-term goals. Of the 10 behavioral health case management files reviewed, the requirement for a plan of care based on the needs assessment was applicable to 8 members. There were 2 members without a plan of care for whom the individualized plan of care requirement was deemed not applicable—the first due to multiple unsuccessful member contact attempts and the second due to CSoC enrollment. However, the case management record	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					documented care planning that included member demographics, member goals, supports and services, and a plan for addressing crisis/preventing unnecessary hospitalizations for 10 of 10 files reviewed. Of 8 applicable files, 7 met the requirement for an individualized plan of care based on the needs assessment. The one member who did not meet the individualized care plan requirement did have a care plan; however, the care plan addressed the behavioral health diagnosis, but not the type 1 diabetes diagnosis. The care coordination notes did address ongoing interventions to address the diabetes diagnosis, including PCP visits; however, care coordination notes also documented a HEDIS alert HbA1c > 9 pending without follow-up, and this young adult member expired in the hospital due to complications of type 1 diabetes. **Recommendation** There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses physical health, as well as behavioral health. In addition, an enhanced process for sharing the plan of care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, including timely follow-up on HEDIS alerts, such as the HbA1C > 9.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Final Review Determination No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing the plan of care as recommended.	
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Treatment plan P/P Individual Treatment Plans Documentation of communication Includes Case Management File Review		Full	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5 and in the 2019 CM Program Description on page 24. The Treatment Plan documents implementation of this requirement.	
6.19.4.2	In compliance with applicable quality assurance and utilization management standards:	P/P Individual Treatment Plans				
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	P/P Individual Treatment Plans Plan of Care Includes Case Management File Review		Substantial	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5, and implementation is supported by the Care Plan document. **File Review Results** Of the 10 case management files for members with care plans, 2 were unable to	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					be contacted by CM for follow-up due to multiple unsuccessful contacts. Of the 8 applicable files, 8 met the requirement for ongoing review and revision as indicated. The requirement for monitoring of outcomes was applicable to 9 of the 10 behavioral health case management files, as 1 was excluded due to multiple unsuccessful outreach attempts. Although the requirement for a care plan was deemed not applicable for the 1 member enrolled in CSoC, ongoing monitoring of outcomes was documented for this member in the care coordination notes. Nine (9) of the 9 files met the requirement for monitoring of outcomes. Seven (7) of 8 applicable files met the requirement for revision of the treatment plan as necessary. The 1 file that did not meet this requirement did document revision of the care plan for the behavioral health diagnosis, but not for diabetes; consequently, the care plan was not revised to address the HEDIS alert HbA1c > 9 and care coordination notes indicated that status for this alert was pending. **<u>Recommendation</u>** There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses ongoing monitoring of both physical health and behavioral health, with revisions made to address changing physical health and behavioral health needs. In addition, an enhanced process for sharing the plan of	as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, particularly timely follow-up on HEDIS alerts, such as the HbA1C > 9. **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing and revising the plan of care on an ongoing basis as recommended.	
6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.	P/P Individual Treatment Plans Plan of Care		Full	This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5. Implementation is supported by POC 723415231_Redacted, POC 724824670_Redacted, and POC 725036027_Redacted.	

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6.28	**Care Management**					
6.28.1	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.	CM records Member Handbook		Full	This requirement is addressed in the Coordination of Care – LA Policy and Procedure on page 1, the Quick Start Guide on pages 1, 4, and 8, and the LA-CM Broch-0917.	
6.28.2 6.28.2.1	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;	P/P member Services Provider handbook Includes Care Management File Review		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 7 and in the Coordination of Care – LA Policy and Procedure. **File Review Results** Of the 10 case management files reviewed, 1 was not applicable due to multiple unsuccessful attempts to contact the member. Of the 9 applicable files, 9 met this requirement, including the 8 identified as having special needs. Of the 10 behavioral case management files reviewed, 10 recorded the member's PCP. Of the 9 applicable behavioral case management files (excluded 1 due to multiple unsuccessful contact attempts), 9 files met the documentation requirement for accessible and comprehensive prevention and treatment services.	
6.28.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k)	P/P member Services Call center documentation		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and	

Core Benefits and Services						
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	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				Procedure on pages7 and 8, and in the Healthy Blue Member Handbook on page 40.	
6.28.2.3	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 for members requiring behavioral health services.	CM records P/P for care coordination Includes Care Management File Review		Substantial	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 8, and the Coordination of Care — LA Policy and Procedure addresses face-to-face engagement for high-risk members or otherwise difficult to reach on page 5, as well as in the Case Management Face-to-Face Intervention-LA Policy and Procedure. **<u>File Review Results</u>** Of the 10 files reviewed, 1 was not applicable due to multiple unsuccessful attempts to contact the member. Of the 9 applicable files, 9 met the general care coordination requirement, including the 8 identified as having special needs. Eight (8) files documented indications for referral, and 8 referrals were made. Of the 9 applicable files, there were 4 with BH diagnoses, and all 4 received care coordination that integrated BH with PH health. Of the 9 applicable files, there were 7 members for whom coordination with the Chronic Care Management Program was applicable and, of these 7, 6 met this requirement. The 1 file that did not meet this requirement was a high-risk pregnancy case with chronic disease other than hypertension/preeclampsia currently monitored as a Prematurity Extension PIP	An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Intervention Tracking Measure (ITM). Of the 10 behavioral health case management files, 10 met the requirements for care coordination, release of information to coordinate with the PCP, and for referrals as indicated. Coordination with the Chronic Care Management Program was applicable to 8 of the 10 files, and 8 of 8 met this requirement. **Recommendation** The MCO should enhance and monitor care management for high-risk pregnant women with chronic physical conditions, not limited to hypertension/preeclampsia. **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) sending an education document is a passive, not a robust intervention, and (3) the MCO did not detail actions taken to develop and implement an enhanced process for care management as recommended.	
6.28.2.4	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	Pain management plans P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 8.	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	ED staff					
6.30	**Care Coordination, Continuity of Care, and Care Transition**					
6.30.0	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 LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to LDH by January 11, 2016. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.	P/P for care coordination P/P for PCP choice Member survey Detailed Workflows		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on pages 2 and 3, with supporting documentation provided in the Pre-Admission Screening and Resident Review (PASRR) workflow, the DSS research SOW_CAHPS project description, the ANQIHSLA_IV_Adult_SP script for Welcome Health Screening Outreach, and the Interim ADHD PIP.	
6.30.1	The MCO shall be responsible for the coordination	P/P for care coordination		Full	This requirement is address in the Continuity	

Core Benefits and Services						
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	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.				of Care – LA Policy and Procedure on page 3.	
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
6.30.2.1	Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) daytime period;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3. **File Review Results** Of the 10 case management files reviewed, 10 met this requirement.	
6.30.2.2	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Coordination of Care – LA Policy and Procedure on page 2. **File Review Results** Of the 10 case management files reviewed, 1 was not applicable due to multiple unsuccessful contact attempts. Of the 9 applicable files, 9 met this requirement.	
6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3, the Coordination of Care – LA Policy and Procedure on page 1, the Quick Start Guide on pages 1, 4, and 8, and the LA-CM Broch-0917. **File Review Results** Of the 10 case management files reviewed, 10 met this requirement.	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
6.30.2.4	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3.	
6.30.2.5	Coordinate care for out-of-network services, including specialty care services;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3.	
6.30.2.6	Coordinate MCO provided services with services the member may receive from other health care providers;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3.	
6.30.2.7	Upon request, share with LDH or 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;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 3.	
6.30.2.8	Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;	P/P for care coordination Provider Handbook		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4 and in the BLA-PM-0006-18 LA Medicaid Provider Manual Update_Final_no_cover on page 11.	
6.30.2.9	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;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.10	Maintain and operate a formalized hospital and/or institutional discharge planning program;	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.11	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	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4. **File Review Results** Of the 10 case management files reviewed, 4) were not applicable due to no hospitalization. Of the 6 applicable files, 6	

Core Benefits and Services						
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	that:				met this requirement. Of the 10 behavioral case management files reviewed, 6 were for members with a hospitalization during the review period, and 6 of 6 files documented discharge planning.	
6.30.2.11.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	P/P for care coordination		Full	This requirement is address in the Continuity of Care – LA Policy and Procedure on page 4 and in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 8.	
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	P/P for care coordination CM records Includes Care Management File Review		Full	This requirement is address in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.11.3.	Coordination with LDH 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.	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.11.4	Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	

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	member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.					
6.30.2.12	Document authorized referrals in its utilization management system;	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.13	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:	P/P for care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 4.	
6.30.2.14	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 LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and	P/P care coordination Court proceedings		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on pages 4 to 5.	
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	P/P care coordination		Full	This requirement is addressed in the Continuity of Care – LA Policy and Procedure on page 5, and is communicated to members in the Healthy Blue Member Handbook on page 39.	
6.36	**Continuity for Behavioral Health Care**					
6.36.1	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.	P/P for BH care continuity Provider contract Provider manual/handbook		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 5, and is communicated to providers in the BLA-PM-0006-18 LA Caid Provider Manual Update_Final_no_cover on	

Core Benefits and Services						
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					page 10.	
6.36.2	The MCO shall establish policies and 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.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 5 and in the Continuity of Care – LA Policy and Procedure on page 8.	
6.36.3	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	P/P for BH care continuity Communication member		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 5. A redacted Crisis Call Notification provided documentation to support implementation of this requirement for follow-up within 48 hours. In addition, a	

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	with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.				member ID card was provided to document the toll-free number.	
6.36.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 5.	
6.36.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 6.	
6.36.6	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.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 6, the Continuity of Care – LA Policy and Procedure on page 9, and the 2019 CM Program Description on pages 5, 6, 7, and 9, with specific agencies listed in the Other Important Phone Numbers document excerpted from the member handbook.	
6.36.7	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.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 6.	
6.36.8	The MCO shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	P/P for BH care continuity		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 6.	
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of	P/P for BH care coordination		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 1.	

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6.36.9.1.4	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 disorders requiring co- management.					
6.36.9.1.5	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.	P/P provider contracting Provider contracts		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 1, and in the Capital Area Amendment cover letter dated 2/22/19.	
6.36.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Provider portal/handbook Training materials		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 1, with implementation supported by the LA_Medicaid_Release of Information Form and the BLA-PM-0006-18 LA Medicaid Provider Manual Update_Final on page 64.	
6.36.9.1.7	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;	Member/provider handbook Educational materials		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 31 and 65, the ER_Brochure_LA_0917.pdf, and the LA CHP Low-Intensity ER Use Brochure 3_E.pdf. In addition, the BLA-PM-0006-18 LA	

Core Benefits and Services						
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					Medicaid Provider Manual Update_Final_no_cover on page 6 indicates that providers should encourage appropriate use of specialists and emergency rooms, with implementation of provider education supported by the provider scorecards.	
6.36.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	P/P coordination of care		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 1.	
6.36.9.1.9	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.	P/P coordination of care		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on pages 1 and 2.	
6.36.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Clinical management system records		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 2, with documentation to support implementation addressed in the Post-Case Conference Note.	
6.36.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	P/P provider initiatives		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page 2, with implementation addressed in the Letter of Agreement FPHSA and Amerigroup, with updates through 2/22/19.	
6.36.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Training materials Provider handbook		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page2, with implementation addressed in the BLAPEC-0804-19 New	

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					Provider Orientation Deck Update FINAL and the Application for Training, Louisiana, Peer Support Specialist document.	
6.36.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CM rounds minutes/schedule		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page2, with documentation of implementation addressed in the Readmission Rounds memorandum starting 4/28/16 through 4/23/19.	
6.36.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.	Meeting minutes		Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and Procedure on page2, with implementation supported in the Agenda Notes – Magellan-Healthy Blue – DCs 20180726 and in the Agenda Notes–Magellan–Healthy Blue–DCs 2018 08 02.	
6.40	**Case Management (CM) Policies and Procedures**					
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH 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:	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 7.	
6.40.1	A process to offer voluntary participation in the Case Management Program to eligible members;	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 7.	
6.40.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 7.	
6.40.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 7.	

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	to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.					
6.40.4	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;	P/P for CM Treatment plan template		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on pages 7 and 8, with supporting documentation of communication in the Healthy Blue Member Handbook on page 39, and of implementation in the Care Plan screen shot.	
6.40.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 8.	
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 8.	
6.40.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 8.	
6.40.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	P/P for CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 8.	
6.41	**Case Management Reporting Requirements**					
6.41	The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH 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:	Evidence of Communication to LDH P/P CM		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 9, with documentation supporting implementation in the Case Management Report/ Healthy Louisiana Reporting submitted 3/19/2019 (file name, HBL039 2018 12 Resubmit 3).	

Core Benefits and Services						
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6.41.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.41.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.41.3	Number of members identified with potential special healthcare needs that self- refer;	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.41.4	Number of members with potential special healthcare needs identified by the MCO;	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 9 and in the A50-Louisiana Pharmacy Restriction Lock-In Program Policy and Procedure, with implementation addressed in the 165 HBL 2018 04 report and 165 HBL through 201903.	
6.41.6	Number of members identified with special healthcare needs by the PASRR Level II authority;	CM/Special health Care needs reports		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 9, with supporting documentation of implementation in the 317 HBL 2018 Q3 report.	
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.41.8	Number of members with assessments resulting in a referral for Case Management.	CM/Special health Care needs reports		Full	This requirement is addressed in the report 039 HBL 2019 01 Resubmit 3.	
6.42	**Chronic Care Management Program (CCMP)**					
6.42.1	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,	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management Policy and Procedure on page 10.	

Core Benefits and Services						
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	particularly diagnosed members who are high utilizers of ED and inpatient services.					
6.42.3	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 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 LDH.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management Policy and Procedure on page 10.	
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH 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:	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management Policy and Procedure on page 10.	
6.42.4.1	Include the definition of the target population;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management Policy and Procedure on page 10, with specific target population definitions specified in the PHM2BC Pop Assessment_FINAL DRAFT.	
6.42.4.2	Include member identification strategies, i.e. through encounter data;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the 2018 Disease Management Program Description Final 03 02 2018 on page 10.	
6.42.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the 2018 Disease Management Program Description Final 03 02 2018 on page 7.	
6.42.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the 2018 Disease Management Program Description Final 03 02 2018 on page 18.	
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including	P/P for CCMP CCMP descriptions		Full	This requirement is addressed the GBD-DM-001 Disease Management (DM) Programs	

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	member criteria and associated interventions;				Policy and Procedure, and in specific DM policies and procedures for asthma, congestive heart failure, diabetes, and HIV, with stratification levels indicated in the 9/26/18 Case Management Policy. On-site, the plans showed examples of programmatic interventions for hepatitis C, obesity, sickle cell anemia, and high utilizers of ED and inpatient services.	
6.42.4.6	Include methods for informing and educating members and providers;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in Appendices D and E of the 2018 GBD Disease Management Program Description Final 03 02 2018.	
6.42.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the 2018 Disease Management Program Description Final 03 02 2018 on page 5.	
6.42.4.8	Address co-morbidities through a whole-person approach;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11.	
6.42.4.9	Identify members who require in-person case management services and a plan to meet this need;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11.	
6.42.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11.	
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11.	
6.44	**CCMP Reporting Requirements**					
6.44.1	The MCO shall submit Chronic Care Management reports quarterly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports.	Communications to LDH		Not Applicable	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on	

Core Benefits and Services						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.114, 438.208)	Suggested Documentation and Reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					5/16/2018.	
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on 5/16/2018.	
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports		Not Applicable	This requirement is addressed in the Case Management– LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on 5/16/2018.	
6.44.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	CCMC reports		Not Applicable	This requirement is addressed in the Case Management– LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on 5/16/2018.	
6.44.3 6.44.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	CCMC reports		Full	This requirement is addressed in the Case Management – LA Policy and Procedure on page 12 and in the 2018 Disease Management Annual Evaluation.	

Provider Network Requirements

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.1	**General Provider Network Requirements**					
7.1.1	The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.					
7.1.2	The MCO must maintain a network that ensures, at 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 and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Provider Network Development and Management Plan.	
7.1.3	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 and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the Provider Network Development and Management Plan.	
7.1.4	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 the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability		Full	This requirement is addressed in the Standards and Measures Monitoring Appropriate Accessibility to Care Policy.	
7.1.5	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 and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Standards and Measures Monitoring Appropriate Accessibility to Care Policy.	
7.1.7	The MCO's network providers shall ensure	P/P for Provider Network		Substantial	This requirement is partially addressed in the	Healthy Blue will add

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Access and Availability			Model Facility Agreement, Physician and Ancillary agreements that discuss the cultural competency requirements. However, this language should be included in the provider manual also. **Recommendation** The MCO should include language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities in the provider manual.	language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities to the provider manual. The next round of provider manual updates will take place this fall, with an updated manual being made available to providers in January 2020.
7.1.8	At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.	P/P for Provider Network P/P for Access and Availability		Full	This requirement is communicated to members via the member handbook and also discussed within the Provider Network Development and Management Plan.	
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity 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 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	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts		Full	This requirement is addressed in the provider manual, the provider agreements, and the Culturally and Linguistically Appropriate Services Policy. CAHPS surveys help determine membership satisfaction, and provider satisfaction surveys are also administered. The MCO conducts provider on-site visits and conducts health disparity assessments to look for any potential disparities. As discussed on-site, if a complaint is received against a provider, operations staff does check to ensure that providers are not conducting any discriminatory practices. Education is provided to providers to who are not in compliance with cultural competency requirements.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclo1.9se 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. LDH will monitor the MCO's compliance with these standards through regular reporting as shown in Provider Network Companion Guide. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:					
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	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual		Full	This requirement is addressed on page 14 of the provider manual.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	appointment shall be arranged within one (1) hour of request;	Provider contracts Member Handbook				
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;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed on page 14 of the provider manual.	
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed on page 14 of the provider manual.	
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;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed on page 14 of the provider manual. The Access to Behavioral Health Care lists the language.	
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the provider manual on page 16.	
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	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the provider manual on page 16.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall	P/P for Provider Network P/P for Provider		Substantial	Although this requirement is addressed in the provider manual on page 14, the	Healthy Blue will update language in the member

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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;	Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook			language in the member handbook does not fully address this requirement. Page 12 of the member handbook states that new members follow the timelines listed in the requirement, but not current members identified as pregnant within the first or second trimester. This was discussed on-site with the provider network management staff and it was clarified that the policy applies to both new and existing members as written in the provider agreement and is addressed with providers in the provider manual. **Recommendation** The MCO should update the language in the member handbook to show the requirement timeline addresses both new and current members newly identified as pregnant.	handbook to show the requirement timeline addresses both new and current members newly identified as pregnant. The next round of member handbook updates will be completed by Q4 2019.
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the member handbook on page 11.	
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	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed on page 3 of the Standards and Measures Monitoring Policy. In addition, the contract language is also found on page 14 of the provider manual and page 21 of the member handbook.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	through a toll-free telephone number at all times.					
7.3	**Geographic Access Requirements**					
7.3.0	The MCO shall comply with the following travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is addressed in the Provider Network Development and Management Plan. The MCO provided their quarterly 220 and 348 Reports to show compliance with the requirement language.	
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .3 Travel distance for members living in rural parishes shall not exceed 30 miles; and .4 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is referenced in the Provider Network Development Plan. In review of the 220 HBL Report, distance requirements are met for all rural parishes, but not for all urban parishes for both adult and adolescent primary care providers. **<u>Recommendation</u>** The MCO should improve access to PCPs for their urban members.	As of July 2019 Adult Urban access is 97.8% and Pediatric Urban access is 98.4%; The Network team is working currently working with 3 large urban PCP groups to be added to our Network. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
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 hospital is available within 30 miles of a	Network Provider Development and Management Plan P/P for Access and		Substantial	This requirement is referenced in the Provider Network Development Plan. The MCO provided	HBL currently has ALL acute care hospitals located in the state under contract.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	Availability GeoAccess reports Requests for exceptions			220 HBL Reports. The Q4 2018 report indicates that distance requirements are mostly met for rural parishes, but they are not met for all urban parishes. **Recommendation** The MCO should improve access to hospitals for their urban members. **Final Review Determination** No change in review determination. As per the language of the contract, it states that travel distance shall not exceed 10 miles for all urban members. There may be a lack of hospitals in certain areas, which can pose as a limitation to the MCO meeting this requirement.	
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 the Provider Network Companion Guide.. LDH 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 LDH for this purpose.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is referenced in the Provider Network Development Plan in Access to Specialists. In review of the 220 HBL reports, all the MCO's specialties (except ob/gyn) meet the access standard for accessibility within 90 miles. All specialties (except ob/ gyn) meet the requirement that at least 75% of members have access to the specialty in a 60-mile distance, and all members have access to specialists within 90 miles. As listed in the Provider Network Development Plan, access to ob/gyns should not exceed 30 miles in rural parishes and shall not exceed 15 miles in urban parishes. Not all urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to ob/gyns	Currently HBL as 96.4% Urban and 95.4% rural access for OBGYN; Many Parishes in Louisiana do not have Hospitals and/or Hospitals that offer OB Services. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					for their rural and urban members.	
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 and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is not referenced in the Provider Network Development Plan. In review of the 220 HBL Geo Access Report, all key geographic urban and rural areas meet the standard for accessibility. Most, but not all, of the other urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to lab services for all rural and urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language.	Overall, HBL has 98.9% urban and 99.9% rural lab access; Network will target these area to improve access; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .3 Travel distance shall not exceed 10 miles in urban parishes; and .4 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is not referenced in the Provider Network Development. The Q4 2018 Reports indicate that distance requirements are met for rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language.	Overall, HBL has 98.3% urban and 100% Rural access. Network will work with our PBM to improve access in needed areas; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .3 Travel distance shall not exceed 10 miles in urban areas; and .4 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is not referenced in the Provider Network Development Plan. Most, but not all, urban and rural parishes meet the access standard for hemodialysis centers. **Recommendation** The MCO should improve access to	Overall, HBL 90.1% urban and 98.4% rural; The state has a limited number of these facilities and will work to improve the network. The contract Geo Access language can be added to the Network

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the requirement language.	Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This requirement is referenced in the Provider Network Development Plan, and 348 HBL Reports were provided for review. 348 HBL Reports show that access standards for behavioral health specialists and psychiatrists are met.	
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is referenced in the Provider Network Development Plan, and 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for behavioral health specialists and psychiatrists are met for rural parishes and mostly met for urban parishes. **Recommendations** The MCO should improve access to behavioral health specialists for all urban members.	Overall HBL has a 98.9% urban access for BH Specialists and will continue to improve access by contracting any available BH Specialists.
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	The requirement language is missing from the Provider Network Development Plan. 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for inpatient psychiatric hospitals are met for rural parishes and urban parishes. **Recommendation** The MCO should include the requirement language in the Provider Network Development Plan. **Final Review Determination**	The health plan follows requirements of the Provider Network Companion Guide.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					No change in review determination. It is understood the MCO follows the Provider Network Companion guide but the language should be included in the Provider Network Development Plan (as seen for the other provider type standards).	
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	The requirement language is missing from the Provider Network Development Plan. 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for ASAM 3.3 are met for 99.9% of urban parish members and 97.7% of rural parish members. Report 359 SBHS Appointment shows time to service. **Recommendation** The MCO should include the requirement language in the Provider Network Development Plan.	
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	348 HBL Reports were provided for review. Q4 2018 348 HBL reports show that access standards for ASAM 3.5 are met for 99.9% of urban parish members and 97.7% of rural parish members. Report 359 SBHS Appointment shows time to service. **Recommendation** The MCO should include the requirement language in the Provider Network Development Plan.	
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports		Full	348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for ASAM 3.7 are met for 100% of urban parish members and rural parish members. Report 359 SBHS Appointment shows time to service.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		Requests for exceptions				
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for ASAM 3.7WM are met for 100% of urban parish members and rural parish members. Report 359 SBHS Appointment shows time to service.	
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	348 HBL Reports were provided for review. Q1 2019 Reports show that the MCO meets the standard. Report 359 SBHS Appointment shows time to service.	
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Full	This was discussed on-site with staff and no requests for exceptions were made during the audit time frame.	
7.3.7.10	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.	P/P Access standards Member handbook		Full	Staff at the on-site audit discussed the MCO assists members with transportation if they choose to visit a preferred provider within a certain distance. The MCO has a transportation vendor, Logisticare, who is able to provide 24-hour round-trip services. Additionally, the MCO provided the Non-emergency Medical Transportation Procedure document.	
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities	Network Provider Development and Management Plan		Full	The Provider Network Development and Management Plan and the Report 220 HBL 2018 Q2 – Q4 Reports address this	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	P/P for Access and Availability Evidence of meeting provider to member ratios			requirement, and ratio requirements are met.	
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.	Network Provider Development and Management Plan Provider contracts Provider manual/handbook P/P for Access and Availability P/P for Monitoring Provider Compliance with Access Standards Plan website Evidence that monitoring was implemented		Full	Staff on-site discussed the quality survey that is done quarterly. A random sample of high-impact, high-volume providers and all providers who failed the prior survey are telephoned to assess they are meeting appointment availability standards. Included in the survey are primary care physicians, high-volume providers, high-impact specialists, behavioral health specialists, and non-prescribers, as well as pediatrics. The MCO provided a 359 SBHS Q1 2019 Appointment Availability presentation and a LA Quarter 3 Appointment Availability Final Data file to show compliance with monitoring of appointment standards. Compliance summary by appointment type and comparisons to 2018 results were displayed in tables. The MCO communicates with providers that telephonic surveys for after-hours coverage are conducted in the 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 the Provider Network Companion Guide. The attestation included with this report shall provide narrative identifying any gaps in coverage and the	GeoAccess reports Communication to LDH/ attestation		Full	The MCO provided the standard 220 HBL Reports, which include the Geo Access Reports for miles and minutes, as well as member-provider ratio reports and a summary narrative captured in a cover letter, along with an email to confirm report submission.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	corrective measures that will address them. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider registry data submitted to LDH 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.					
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 the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.	GeoAccess reports Communications to LDH		Full	The MCO provided the standard 220 HBL Reports, which include the Geo Access Reports for miles and minutes, as well as member-provider ratio reports and a summary narrative captured in a cover letter, along with an email to confirm report submission.	
7.6		**Provider Enrollment**				
7.6.1	**Provider Participation -**					
7.6.1.6	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.	Network Provider Development and Management Plan P/P for Provider Network		Full	This is satisfied by the provider agreements. As discussed on-site, the MCO contracts with or makes an effort to contract with all provider types, including PRTFs, as per regulatory requirement and listed in the Provider Network Companion Guide.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• 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 LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • 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); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).		-			
7.6.1.7	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	Network Provider Development and Management Plan P/P for Provider Network		Full	As discussed on-site, the MCO contracts with or makes an effort to contract with all provider types, including PRTFs, as per regulatory requirement and listed in the Provider Network Companion Guide.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	detailing efforts that were made.					
7.6.1.8	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 and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Provider Network Development Plan in the section Reasonable and Good-Faith Efforts.	
7.6.1.9	The provisions above do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do 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 and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Provider Network Development Plan in the section Limiting Participation.	
7.6.1.10	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 and Management Plan P/P for Provider Network P/P for Provider Selection and Retention Evidence of timely notice of denied provider requests for participation Sample notice to providers		Full	This requirement is addressed in the Provider Network Development Plan in the section Limiting Participation.	
7.6.1.11	The MCO shall work with LDH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	P/P care coordination Meeting/Forum Meetings		Full	This requirement is addressed in the Provider Network Development Plan on page 24.	
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
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.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Credentialing P/P for Provider Selection and Retention		Full	This requirement was addressed in discussions with staff on-site about the provider credentialing process and is addressed with the credentialing policies on ongoing sanctions and initial applications. This requirement is also addressed in the Provider Network Development Plan on page 24.	
7.6.2.2 7.6.2.2.1 7.6.2.2.2 7.6.2.2.3 7.6.2.2.4 7.6.2.2.5 7.6.2.2.6	The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings: .1 Revocation of the provider's home and community-based services license or behavioral health service license; .2 Exclusion from the Medicaid program; .3 Termination from the Medicaid program; .4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41); .5 Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC	P/P for Provider Network		Full	This requirement was addressed in discussions with staff on-site about the provider credentialing process and is addressed with the credentialing policies on ongoing sanctions and initial applications. This requirement is also addressed in the Provider Network Development Plan on page 24.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.					
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	P/P for Provider Network		Full	This requirement is addressed in the provider contract.	
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)] The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(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 and Management Plan P/P for Provider Network P/P for Provider Selection and Retention P/P for Provider Credentialing		Full	This language is addressed in the Provider Network Development Plan.	
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.	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook P/P for Provider Credentialing		Full	This language is addressed in the Provider Network Development Plan.	
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to	P/P for Provider Network P/P for Provider Termination Sample notice to providers Sample notice to LDH		Substantial	In the Provider Network Development Plan, on page 24, it states that the MCO will provide immediate notification to the provider and notify LDH of the termination after the written notification to the provider soon after, but no later than 7 calendar days. This is not in line with current requirement	Timely Notification of Participating Provider Termination policy, #4 Page 6 of 8

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	provider notification.				language. However, the provider termination process was discussed on-site with staff, who stated that termination notices are sent out immediately or as soon as a decision has been reached on a provider's status and LDH has been informed of providers that should be terminated for cause. A sample provider termination letter was provided after the on-site. A sample email to LDH notifying them of all provider termination letters was also provided. Additionally, the standard Report 145 HBL lists the names of providers who are terminated for cause. **Recommendation** The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language. **Final Review Determination** No change in review determination. Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.	
7.6.3.5	If termination affects network adequacy, the MCO shall include in the notification to LDH their plans to notify MCO members of such change and	P/P for Provider Network P/P for Provider Termination		Full	The requirement language is addressed in the Timely Notification of Participating Provider Termination Policy. At the on-site	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	strategy to ensure timely access for MCO members through different in-network and/or out-of network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure there will be no stoppage or interruption of services to members.	Sample notice to members			audit, staff explained that members will be transitioned upon notice of provider terminations and the MCO generates letters to members to notify them of provider terminations.	
7.6.3.6	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 care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	P/P for Provider Network P/P for Provider Termination Sample notice to members Member Handbook		Substantial	The requirement language is partially addressed in the Timely Notification of Participating Provider Termination Policy. As discussed at the on-site audit, termination processes and member notifications are coordinated simultaneously. **Recommendation** The MCO should update the Timely Notification of Participating Provider Termination Policy to include the criterion of MCO members who have received care "within the past two years." **Final Review Determination** No change in review determination. Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.	Timely Notification of Participating Provider Termination – LA; # a Page 6
7.7	**Mainstreaming**					
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be	Provider contracts Provider Handbook/Manual		Substantial	This requirement is partially addressed in the provider manual on page 65. The meaning of	Healthy Blue will define mainstreaming

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.				the requirement is addressed on pages 14 and 15 that services should not be administered to members in any way different from the public or those providers should not show preference to other insured or private-pay patients. However, the provider contracts do tell providers that they must not discriminate members based on sex, race, creed, and other discriminating factors, such as a person's status as a program contract beneficiary. **Recommendation** The MCO should define mainstreaming appropriately within the Provider Manual as well as communicate mainstreaming requirements in their various provider contracts.	appropriately within the Provider Manual. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.
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, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider contracts Provider Handbook/Manual Member Handbook		Substantial	The requirement is partially addressed in the provider contracts in the Non-discrimination. section. **Recommendation** The MCO should indicate in their provider contract(s) and provider manual that they will take affirmative action to mainstream and ensure members are provided covered services without discrimination.	Healthy Blue will indicate in the provider manual that we will take affirmative action to mainstream and ensure members are provided covered services without discrimination. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts Provider Handbook/Manual		Full	This requirement language is addressed in the provider contracts.	
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.	Provider contracts Provider Handbook/Manual		Full	This requirement is addressed on pages 14 and 15 of the provider manual.	
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.	Provider contracts Provider Handbook/Manual		Full	This requirement is addressed on pages 14 and 15 of the provider manual.	
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 LDH in writing	P/P provider contracts Provider Contract Provider Handbook		Full	This requirement is addressed in the Provider Network Development Plan.	
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.	P/P provider contracts Provider Contract Provider Handbook		Full	This requirement is addressed on page 65 of the provider manual.	
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;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
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;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 10 of the provider manual.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	P/P for PCP responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
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;	P/P for PCP responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
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;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 11 of the provider manual.	
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
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.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider contracts.	
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.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 11 of the provider manual.	
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 10 of the provider manual.	
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
7.8.2.11	Participating in the MCO's case management	P/P for PCP Responsibilities		Full	This requirement is addressed on page 12 of	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	team, as applicable and medically necessary.	Provider Handbook/Manual Provider contracts			the provider manual.	
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.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed on page 12 of the provider manual.	
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).	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports		Full	This requirement is addressed on page 28 of the Provider Network Development Plan.	
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.	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports		Substantial	The requirement language is not in the Provider Network Development Plan. However, the Q2 2018 Geo Access Report indicates 95.8% of urban parish members have access to an ob/gyn in a 15-mile radius and 95.4% of rural parish members have access to an ob/gyn provider in a 30-mile radius. **<u>Recommendation</u>** The MCO should include this language in their Provider Network Development Plan. **<u>Final Review Determination</u>** No change in review determination. The rebuttal version of the Network Development Plan document, which was	Network Development Plan, Section 7.8.3.3, page 30

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					provided in response to our recommendation, is not the same documentation that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the document with the added language for the next audit review.	
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 the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider types		Full	The MCO provided provider contract templates and Geo Access Reports to show compliance with this requirement.	
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements set in this Section and in the Provider Network Companion Guide.					
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 LDH the MCO does not meet the access standards specified in the Contract.	P/P for Provider Network P/P for Access to Specialty Providers		Full	This requirement is addressed on page 28 of the Provider Network Development Plan.	
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	P/P for Provider Network P/P for Access to Specialty Providers		Full	This requirement is addressed on page 28 of the Provider Network Development Plan.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	P/P for direct access services				
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.					
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: .1 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. .2 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 42 CFR, Parts 412 and 413.	P/P for Provider Network GeoAccess reports		Full	This requirement language is addressed in the Provider Network Development Plan on pages 28 and 29; it states that the MCO has 200 hospitals in its network. A review of the 220 and 348 HBL 2018 Q4 Reports are sent to the state quarterly for network adequacy.	
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	P/P for Provider Network GeoAccess reports		Full	This requirement is addressed by the section Annual Needs Assessment in the Provider Network Development Plan and was addressed with staff at the on-site audit.	
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.	P/P for Provider Network GeoAccess reports		Full	This requirement is addressed by the section Annual Needs Assessment in the Provider Network Development Plan and and was addressed with staff at the on-site audit.	
7.8.5	**Tertiary Care**	P/P for use of out-of-		Full	This requirement is addressed in the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 providers P/P for providing access to tertiary care GeoAccess reports			Provider Network Development Plan and by the Geo Access Reports.	
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 member's PCP if that provider is not a women's health specialist.	P/P for direct access services		Full	This requirement is addressed in the Provider Network Development Plan and by the Geo Access Reports.	
7.8.6.1	The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.	P/P for direct access services		Full	This requirement is addressed in the Provider Network Development Plan and by the Geo Access Reports.	
7.8.6.2	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	P/P for direct access services Member Handbook		Full	This requirement is addressed in the Provider Network Development Plan.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	to make available all family planning services to MCO members as specified in this RFP.					
7.8.6.3	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.	P/P for direct access services Member Handbook		Full	This requirement is addressed in the member handbook and in the provider manual.	
7.8.6.5	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	P/P for Direct Access Services		Full	This requirement is addressed in the Provider Network Development Plan.	
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in 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.	P/P for Prenatal Care Services Access P/P for Assignment of PCPs including Auto Assignment		Full	Prenatal care services are addressed in the Provider Network Development Plan and in the Perinatal Services Policy.	
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to,	Evidence of availability of other medical service providers		Full	In review of the network adequacy reports, detailed lists of network providers include these other service providers.	

Provider Network Requirements						
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	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.					
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.	P/P for Provider Network Contracts with FQHC/RHCs		Full	This requirement is addressed in the Provider Network Development Plan.	
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the LDH 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.	P/P for Provider Network Contracts with SBHCs		Full	This requirement is addressed in the Provider Network Development Plan.	
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, STI, family planning).	P/P for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the Provider Network Development Plan and by the submission of the Louisiana Office of Public Health Contract and Amendments document.	
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for 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.	P/P for Provider Network Contract with Louisiana OPH		Full	This requirement is evidenced by the submission of the Louisiana Office of Public Health Contract and Amendments document.	
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services	P/P provider network P/P care coordination		Full	This requirement is addressed in the Provider Network Development Plan and by	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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 reports			the 348 HBL Reports, where pediatric members' accessibility to PRTFs is reported.	
7.8.14.2	The MCO shall ensure its provider network offers a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. The provider network shall be adequate for the anticipated number of members for the service area. The service array shall comply with the waivers and Medicaid State Plan requirements.					
7.8.14.3	The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.			Full	This requirement is addressed in the Provider Network Development Plan. MCO network includes behavioral health specialists who can assist with the needs of members who have behavioral health issues or special needs. On-site, MCO's provider network staff discussed how they use single-use agreements for providers, such as psychiatric residential treatment facilities, to address the needs of their members, such as adolescents with behavioral health issues, when there is a gap in their provider network. In order to address a gap in care for adolescents requiring certain services, Healthy Blue partnered with Arcadia Healthcare to take on a substance abuse	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					facility.	
7.8.14.4	The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.		Partnered with Arcadia healthcare to help address worked to take a substance abuse facility to help address a need to address a gap in care for adolescents requiring	Full	This requirement is addressed in the Provider Network Development Plan. The MCO network includes behavioral health specialists who can assist with the needs of members who have behavioral health issues or special needs. On-site, MCO's provider network staff discussed how they use single-use agreements for providers, such as psychiatric residential treatment facilities, to address the needs of their members, such as adolescents with behavioral health issues, when there is a gap in their provider network. As an example, in order to address a gap in care for adolescents requiring certain services, Healthy Blue recently partnered with Arcadia Healthcare to take on a substance abuse facility to meet the needs of their members.	
7.8.14.5	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed by the Provider Network Development Plan and the Access to Behavioral HealthCare Policy.	
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed by the Provider Network Development Plan and the Access to Behavioral HealthCare Policy.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.					
7.8.14.7	The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed within the Provider Network Development Plan on page 31.	
7.8.14.8	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, warm line, crisis counseling crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, mobile crisis teams, and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. If shortages in provider network sufficiency are identified by LDH, the MCO shall conduct outreach efforts approved by LDH, 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	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed within the Provider Network Development Plan on page 31. The crisis hotline is listed in the member handbook as an important number and behavioral health services are discussed within various sections of the member handbook. On-site, MCO's provider network staff discussed how they use single-use agreements for providers, such as psychiatric residential treatment facilities, to address the needs of their members, such as adolescents with behavioral health issues, when there is a gap in their provider network.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	provided and reimbursed through the MCO, including meals and lodging as appropriate.					
7.8.14.10	The MCO shall require behavioral health providers to screen for basic medical issues.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Provider Network Development Plan.	
7.8.14.11	The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Provider Network Development Plan.	
7.8.14.12	The MCO shall report the number of out-of-state placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	P/P provider network P/P care coordination		Full	This requirement is addressed in the Provider Network Development Plan.	
7.8.15 7.8.15.1	**Indian Health Care providers (IHCPs)** The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.	P/P provider network P/P care coordination Network reports		Full	This requirement is minimally addressed in the Provider Network Development Plan. It states that the MCO will comply with the state RFP for contracting with IHCPs. It was, however, discussed with staff on-site that there is a company liaison to all tribes in Louisiana.	
7.8.15.2 7.8.15.2.1 7.8.15.2.2 7.8.15.2.3	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows: • At a rate negotiated between the MCO and the IHCP; or • In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and • Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled			Full	This requirement is communicated to	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.				members in the member handbook.	
7.8.15.4	The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.			Full	This requirement is communicated to members in the member handbook.	
7.8.15.5 7.8.15.5.1 7.8.15.5.2	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .3 Indian members are permitted by the MCO to access out-of-state IHCPs; or .4 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	P/P provider network P/P care coordination Network reports		Substantial	The first bulleted requirement is communicated to members in the member handbook. The second bulleted requirement is not listed specifically in the Provider Network Development Plan. **Recommendation** The MCO should add the language pertaining to timely access to IHCPs specifically addressed in the Provider Network Development Plan.	Network Development Plan, Indian Health Care Providers (IHCPs), Page 35-36
7.8.15.6	The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.	P/P provider network P/P care coordination Network reports		Full	This requirement is communicated to members in the member handbook.	
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 LDH 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, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.68):					
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 4.	
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 4.	
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;	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 4.	
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 4.	
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.	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 5.	
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:	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 6.	
7.9.2.1	Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 6.	
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 6.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	members in the service area;					
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 6.	
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 7.	
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 7.	
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 8.	
7.9.2.7	Timely Access	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 8.	
7.9.2.8	Service Area	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 8.	
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health , • Special Conditions for Prenatal Providers, • Second Opinion • Out-of-Network Providers	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 8.	
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. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.	Provider Network Development and Management Plan		Full	This is addressed by the Provider Network Development Plan on page 9.	
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with	Provider Network Development and		Full	The requirement is addressed by the Provider Network Development Plan on page	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Management Plan			11.	
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory		Full	The requirement is addressed by the Provider Network Development Plan on page 11.	
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 LDH quarterly, or upon material change (as defined in the Glossary) or upon request.	Provider Network Development and Management Plan GeoAccess reports		Full	This requirement is addressed by the Geo Access Reports the MCO produces and submits quarterly.	
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 11.	
7.9.5.2	Monitor network compliance with policies and rules of LDH 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;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.5.3	Evaluate the quality of services delivered by the network;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	

Provider Network Requirements						
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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	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
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;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.5.7	Provide training for its providers and maintain records of such training;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
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 LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	P/P for Network Development and Management		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
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 LDH at the end of the first year of operations and annually thereafter.	P/P for Evaluation of Network Provider Development and Management Plan		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.7	MCO Network Development and Management policies shall be subject to approval by LDH, Medicaid Managed Care Section and shall be monitored through operational audits.	Evidence of submission of P/P for Network Development and Management to LDH		Full	The requirement is addressed by the Provider Network Development Plan on page 12.	
7.9.8	**Specialized Behavioral Health Network**	Network development		Full	The requirement is addressed by the	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Development and Management Plan An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to LDH 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.	Implementation plan P/P provider network			Provider Network Development Plan on page 13.	
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 development Implementation plan P/P provider network		Full	The requirement is addressed by the Provider Network Development Plan on page 13.	
7.9.8.2	The MCO's Network Development and Management Plan shall include the following 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;	Network development Implementation plan P/P provider network		Full	The requirement is addressed by the Provider Network Development Plan on page 13.	
	• 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 development Implementation plan P/P provider network		Full	The requirement is addressed by the Provider Network Development Plan on page 13.	
	• 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 LDH quarterly by contract year,	Network development Implementation plan P/P provider network		Full	The requirement is addressed by the Provider Network Development Plan on page 14.	

Provider Network Requirements						
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	upon material change of the network, or upon request;					
	• 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 enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.	P/P network Needs assessment findings		Full	The requirement is addressed by the Provider Network Development Plan on page 14.	
	• 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	Network development Implementation plan P/P provider network		Full	The requirement is addressed by the Provider Network Development Plan on page 14 and is evidenced by Geo Access Reports. Additionally, the 359 SBHS Appointment Availability Standards Report was provided to show monitoring of BH provider appointments.	

Provider Network Requirements						
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	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.					
7.9.8.3	The MCO shall submit to LDH as part of its annual Network Development and Management Plan, and upon request of LDH, 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; • 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.	Evidence of submission of network development Plan to LDH Network and development plan		Full	The requirement is addressed by the Provider Network Development Plan on page 14 and the submission of the Network Development Plan to LDH was discussed on-site with the MCO.	
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:	Network development and management plan		Full	The requirement is addressed by the Provider Network Development Plan on pages 14 and 15.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• 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.					
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: • 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	Network development and management plan		Full	The requirement is addressed by the Provider Network Development Plan on pages 14 and 15.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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,	Network development and management plan		Full	The requirement is addressed by the Provider Network Development Plan on page 15.	

Provider Network Requirements						
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	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 development and management plan		Full	The requirement is addressed by the Provider Network Development Plan on page 16.	
7.11	**Material Change to Provider Network**					
7.11.1	The MCO shall provide written notice to LDH, 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 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	Evidence of communications with LDH P/P provider contracting		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations policy and a sample email to LDH of the provider termination notification letters.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 value-added benefits and services, payments, or eligibility of a new population.	Evidence of communication with LDH P/P Provider network		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and a sample email to LDH of the provider termination notification letters.	
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.	Request for approval communications Notification to Member		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy.	
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.	Request for approval		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy.	
7.11.5	If LDH 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, LDH will expedite the approval process.					
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid	Notification to LDH		Full	This requirement is addressed in the Timely	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Managed Care Section 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.	P/P provider network			Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff.	
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.	Provider contracts P/P provider contracting		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff.	
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: .1 Provide written notice to LDH, 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	Evidence of notifications P/P provider network		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH.					
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.	P/P provider network		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff.	
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 LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. .1 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	Request for approval letter		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff. There were no situations that necessitated the use of a Request For Approval letter during the audit period.	

Provider Network Requirements						
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	revise the service plan to address any changes in services or service providers.					
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to LDH 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.	Written plan P/P provider network		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy.	
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 LDH (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).	Tracking report P/P service coordination		Full	This requirement is addressed in the Timely Notification of Participating Provider Terminations Policy and discussed on-site with MCO staff.	
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).	P/P for Coordination with Other Service Providers		Full	This requirement is addressed in the Coordination of Care Policy.	
7.13	**Provider Subcontract Requirements**					
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against	P/P for Network Management		Full	This requirement is addressed in the provider agreements and the Network	

Provider Network Requirements						
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	particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P/P for Provider Selection and Retention			Development Plan.	
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**					
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the policies on credentialing, initial applications, recredentialing, ongoing sanctions monitoring, and professional competence.	
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not	P/P provider contracting		Full	The MCO follows NCQA standards for credentialing processes and has several credentialing policies that address the contract language for contracting with various agencies and BH facilities, and the MCO follows LDH's policy on requiring agencies to supply proof of accreditation. Licensure and accreditation requirements are addressed in the LA Model Facility provider contracts.	

Provider Network Requirements						
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	accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).					
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.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	The MCO provided the LA Standardized Credentialing Application and the CAQH Credentialing Application templates. These are the standard forms used by the MCO for provider credentialing. On-site, the MCO discussed the process of credentialing was the same for delegated entities, such as Ochsner Health System. Application forms and checklists provided for on-site file reviews show that the data elements on the standard credentialing forms are captured. Annual monitoring activities, such as credentialing audits, are conducted on a sample of files annually to ensure delegated entities meet credentialing standards, and the MCO requests corrective action plans from those entities whose audit results do not have a 95% pass rate. On-site file reviews verified the MCO follows	

Provider Network Requirements						
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					credentialing standards, such as verification of current licenses, work history, malpractice coverage, and professional liability claims history, education or board certification verification, DEA/CDS certifications, exclusion lists, state, federal, Medicare, and Medicaid sanctions including those published or maintained by OIG, AMA, or NPDB. For re-credentialing files, the files were verified for timeliness of re-credentialing, board certifications if applicable, current licenses, valid DEA/CDS certifications if any, and the attestation. **Credentialing File Review Results** Five (5) out of 5 file met the standards for the credentialing application. File 1 was the MCO's credentialing file, and shows the use of the LA Standard Credentialing application form. Files 2, 3, 4, and 5 are delegated credentialing files and use the standard application form from their credentialing delegated entities, Ochsner Health System and St. Jude's Children Hospital. These application forms capture the elements seen on the LA and CAQH standard credentialing application. **Re-credentialing File Review Results** Five (5) out of 5 file met the standards for the credentialing application. Files 1, 3, 4, and 5 used the CAQH application form. File 2 is an Ochsner Health System credentialing file, and the application captures elements on the standard LA credentialing forms.	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for	P/P for credentialing & recredentialing		Full	This was discussed on-site with the MCO's credentialing staff and it was confirmed that	

Provider Network Requirements						
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	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.				delegated entities follow the credentialing requirements as listed in their contract with the MCO.	
7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.	P/P for credentialing & recredentialing		Full	This is confirmed in on-site discussions with the MCO that they meet NCQA and LDH standards for credentialing.	
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:	P/P for credentialing & recredentialing P/P for subcontractor delegation and requirements Credentialing subcontractor contract Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the MCO's credentialing policies, is communicated to delegated entities, and on-site file reviews verify that the MCO meets the timeliness of processing credentialing applications. Credentialing files were reviewed to see if they were processed within 60 days. If dates were questionable in the file reviews, staff displayed the application receipt dates, and credentialing completion dates the Cactus credentialing system. **Credentialing File Review Results** Five (5) out of 5 files met the standards for timely processing credentialing applications.	
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	P/P for credentialing & recredentialing		Full	This requirement is fulfilled by the MCO, as discussed with staff on-site.	
7.14.5.2	Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or	P/P for credentialing & recredentialing Provider Directory Evidence of submission of the Provider Directory		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff.	
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff. The MCO provided a sample Credentialing Denial Letter.	

Provider Network Requirements						
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7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.	P/P for credentialing & recredentialing Delegation Contracts		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff that delegated credentialing bodies adhere to contract language and LDH standards for credentialing. Monitoring activities are in place for delegated credentialing partners, and yearly audits are conducted on a sample of files to see that credentialing standards are met.	
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	P/P for credentialing & recredentialing		Full	This requirement is met in the credentialing policy on additional state-specific language for Louisiana.	
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.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff.	
7.14.9	The MCO shall notify LDH 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.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff. This is also verified by the review of the re-credentialing files at the on-site audit. **Re-credentialing File Review Results** Five (5) out of 5 files were re-credentialed within 3 years of the initial credentialing appointment.	
7.14.11	The MCO shall develop and implement policies	P/P for credentialing &		Full	This requirement is addressed in the MCO's	

Provider Network Requirements						
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	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.	recredentialing			credentialing policies and was discussed on-site with staff.	
7.14.12	The MCO shall develop and implement a mechanism, subject to LDH 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 (30) days from the date the Contract is signed and at the time of any change.	P/P for credentialing & recredentialing P/P for reporting provider quality deficiencies Documented process for reporting quality deficiencies resulting in suspension or termination Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the MCO's credentialing policies and was discussed on-site with staff. A sample email on Provider Termination notification letters to LDH was provided.	
7.14.13	The MCO shall develop and implement a provider dispute and appeal process, with LDH'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.	P/P for credentialing & recredentialing P/P for provider dispute and appeal process Documented provider dispute and resolution process for sanctions, suspensions and terminations Evidence of timely process submission		Full	This requirement is met in the credentialing policy on additional state-specific language for Louisiana.	
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					

Provider Network Requirements						
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	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:	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the Provider Education and Communication Policy.	.
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the Provider Education and Communication Policy.	
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the Provider Education and Communication Policy.	
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the Provider Education and Communication Policy.	
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.	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the Provider Education and Communication Policy.	
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	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in the provider manual.	

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	and information disclosure requirements related to physician incentive plans.	Member Handbook				

Utilization Management

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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 LDH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	P/P for UM Evidence of timely submission of P/P for UM		Full	This requirement is addressed in the UM Program Description. In addition Healthy Blue provided an email showing LDH approval of their policies.	
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:					
8.1.2.1	Are adopted in consultation with contracting health care professionals;	P/P for UM		Full	This requirement is addressed on page 15 of the UM Program Description. In addition, the Medical Policy and Technology Assessment Committee (MPTAC) reports were provided as evidence.	
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;	P/P for UM		Full	This requirement is addressed in the UM Program Description on pages 12, 15, 16, 21, 22 as well as the Medical Policy and Technology Assessment Committee (MPTAC) reports.	
8.1.2.3	Are considerate of the needs of the members; and	P/P for UM		Full	This requirement is addressed in the UM Program Description; page 16 and the Clinical Criteria for Utilization Management Decisions Core Process Policy.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	P/P for UM		Full	This requirement is addressed in the UM Program Description; page 16 and the Clinical Criteria for Utilization Management Decisions Core Process Policy.	
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	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 13 and the	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of health care services;				Clinical Criteria for Utilization Management Decisions Core Process Policy on page 1.	
8.1.3.2	The data sources and clinical review criteria used in decision making;	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 21 and the Clinical Criteria for Utilization Management Decisions Core Process Policy on page 2.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	P/P for UM		Full	This requirement is addressed in the UM Program Description.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 34. It is also addressed in the Informal Reconsiderations policy.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	P/P for UM		Full	This requirement is addressed in the UM Program Description.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	P/P for UM		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on; pages 4, 5, 15.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 54.	
8.1.3.8	Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the UM Program Description on pages 12 and 13 and the Mental Health Rehabilitation Services – LA policy on pages 8 and, 9.	
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;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the UM Program Description on page 12.	
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	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the UM Program Description on page 13.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	to reentry into the community, including referral to community providers;					
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	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the UM Program Description on page 13.	
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.	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the UM Program Description on page 13.	
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	P/P for UM P/P for guideline development coordination P/P for guideline research, selection, adoption, review, update, & update schedule Sample adopted guidelines		Full	This requirement is addressed in the UM Program Description on page 22.	
8.1.5	The MCO shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	P/P for UM P/P for guideline dissemination Sample adopted guidelines		Full	This requirement is addressed in the UM Program Description on pages 22, 35 and 38.	
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	Provider contracts Compliance reports		Full	This requirement is addressed in the UM Program Description on pages 12 and 22.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	compliance.					
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:	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the UM Program Description on pages 12 and 21.	
8.1.6.1	The vendor must be identified if the criteria was purchased;	P/P for UMP/P for medical management criteria		Full	This requirement is addressed in the UM Program Description on page 22.	
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;	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the UM Program Description on page 22.	
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the UM Program Description on page 22.	
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.	P/P for UM P/P for medical management criteria		Full	This requirement is addressed in the UM Program Description on page 22.	
8.1.7	UM Program medical management criteria and practice guidelines shall be posted to the MCO's website. If the MCO uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, the MCO may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the MCO must provide the specific criteria and practice guidelines utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	P/P for UM P/P for guideline dissemination		Full	This requirement is addressed in the UM Program Description on page 22. This was also confirmed by viewing the guidelines on Healthy Blue's website.	
8.1.8	The MCO shall have written procedures listing the information required from a member or health	P/P for UM P/P for required		Full	This requirement is addressed in the UM Program Description on page 24 and in the	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	information P/P for additional information			Clinical Information for Utilization Reviews – Core Process – LA policy on pages 3 and 4.	
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 necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 4 and in the Pre-Certification of Requested Services – LA policy on page 1.	
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.	P/P for UM Staffing plan		Full	This requirement is addressed in the UM Program Description on page 20 and the Clinical Criteria for Utilization Management Decisions Core Process policy on page 13. In addition, Healthy Blue provided an Organization chart and job descriptions. At the onsite, Healthy Blue discussed that they monitor membership to determine if they are meeting work load. They also review the turnaround times (TAT) to gauge staffing .	
8.1.11	The MCO shall use LDH'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.	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 23 and Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process – LA policy on page 5.	
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	P/P for UM Staffing plan		Full	This requirement is addressed in the UM Program Description on pages 18, 20 and 23.	
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	P/P for UM		Full	This requirement is addressed in the UM Program Description on pages 18, 20 and 23.	
8.1.15	The MCO shall ensure that only licensed clinical	P/P for UM		Full	This requirement is addressed in the UM	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	Includes UM File Review			Program Description on pages 20, 23 and 24. **File Review Results** Five (5) of 5 files were compliant. Five (5) of 5 files were not applicable since they were not clinical in nature.	
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.	P/P for UM		Full	This requirement is addressed in the UM Program Description on pages 12 and 24.	
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.	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 13.	
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. 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	P/P for UM		Full	This requirement is addressed in the UM Program Description on pages 12 and 24. It is also addressed in the Provider Manual on page 99 and Member Handbook on page 14.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 14. It is also addressed in the Provider Manual on page 99 and Member Handbook on page 14.	
8.4	**Service Authorization**					
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. It is also addressed in the Prior Authorization Liaison (PAL) Policy-LA on page 4.	
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. Gee and Wells v. Gee* for initial and continuing authorization of services that include, but are not limited to, the following:	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. This requirement is also addressed in the Clinical Criteria for Utilization Management Decisions Core Process on page 14	
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 timely manner;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. It is also addressed in the Prior Authorization Liaison (PAL) Policy-LA on page 4.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description on page 25 and the Clinical Criteria for Utilization Management Decisions Core Process on page 12.	
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	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. It is also addressed in the Pre-Certification of Requested Services – LA on page 2.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	who has appropriate clinical expertise in treating the enrollee's condition or disease;					
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;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25 and the Member Handbook on page 54	
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	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. It is also addressed in the Pre-Certification of Requested Services – LA on page 4. An authorization system screen shot was also provided as evidence.	
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.	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UM Program Description page 25. It is also addressed in the Pre-Certification of Requested Services – LA on page 4.	
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.	P/P for UM P/P for service authorization		Full	This requirement is addressed in both the Pre-Certification of Requested Services – LA policy on page 7 and the Clinical Criteria for Utilization Management Decisions Core Process policy on page 15.	
8.4.4	Not later than July 1, 2018, the MCO shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.	P/P prior authorization P/P for UM		Full	This requirement is addressed in the Observation-LA policy; BLAPEC-0936-18 EXPRESS Observation Notice and meeting invites for the LDH sponsored Observation Policy Meetings in April 2018.	
8.4.5	The MCO shall perform prior authorization and	P/P prior authorization		Full	This requirement is addressed in the UM	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals.	P/P for UM			Program Description on page 28; Clinical Information for Utilization Management Reviews - Core Process on page 3 And the Clinical Criteria for Utilization Management Decisions Core Process on page 15.	
8.4.5.1	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].	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 28 and the Clinical Information for Utilization Management Reviews - Core Process-LA on page 4.	
8.4.5.2	Concurrent utilization reviews are administrative in nature and should not be reported to LDH 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 psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	P/P for UM		Full	This requirement is addressed in the UM Program Description on page 28 and the Clinical Information for Utilization Management Reviews - Core Process-LA on page 4.	
8.4.5.3	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,	P/P for UM Evidence of timely submissions Notification communication to member/provider		Full	This requirement is addressed in the UM Program Description on page 28 and the Clinical Information for Utilization Management Reviews - Core Process-LA on page 4.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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					

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.					
8.4.6	Certification of Need (CON) for PRTFs					
8.4.6.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.					
8.4.6.2	The MCO shall ensure LMHPs are included in the team responsible for certification and 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.	P/P Service utilization P/P Certification/recertification		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on page 16.	
8.4.6.3	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	P/P for UM LMHP Subcontract		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on page 16.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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).					
8.4.6.4	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.	P/P certification		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on page 16.	
8.4.6.5	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. o Upon completion of the screen, if the PRTF is approved, within 48 hours the MCO shall notify in writing the provider requesting the certification of the results, the member/guardian and, with member guardian consent, the referring party requesting the PRTF services on behalf of the youth. If approved, the MCO shall, in consultation with the member's guardian and referring party, locate a PRTF provider appropriate to meet the member's needs with availability to admit the member. o If denied, the MCO shall notify the provider requesting the certification immediately and within 48 hours provide written notification to the provider	P/P certification Tracking report P/P for UM Hospital reports		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on page 16. Also provided as evidence was a PRTF case example.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	requesting the certification of the results, the member/guardian and, with the member/guardian consent, the referring party requesting the PRTF services on behalf of the youth. The notification shall include: information on alternative community services that may meet the member's needs to ensure health and safety, including information on available providers of those services, the right of the member to appeal, and the process to do so. For youth pending release from a secure setting for whom a PRTF is being requested, the MCO is required to coordinate the completion of the screen and the CON prior to the youth's release if it is anticipated that the youth will be re-linked to the MCO following release. o Generate a prior authorization for each PRTF admission within 48 hours of completion of the screen. o Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. o Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. o Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.					
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	P/P for UM P/P for standard service authorization		Full	This requirement is addressed in the UM Program Description on page 30 and the Concurrent Review (Telephonic and On-Site)	Weekly TAT

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.				and On-site Review Protocol Process-LA on page 19. In addition, Healthy Blue provided quarterly Authorization summary reports as evidence. At the onsite review Healthy Blue reported that they also use turnaround time (TAT) reports to determine compliancy.	
8.5.1.1.1 8.5.1.1.1.1 8.5.1.1.1.2	The service authorization decision may be extended up to fourteen (14) additional calendar days if: • The member, or the provider, requests the extension; or • The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.			Full	This requirement is addressed in the UM Program Description on page 30 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 19.	
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.	P/P for UM P/P for concurrent review determinations		Full	This requirement is addressed in the UM Program Description on pages 30 and 31 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 19. In addition, Healthy Blue provided quarterly Authorization summary reports as evidence.	
8.5.2	**Expedited Service Authorization**					
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	P/P for UM P/P for expedited service authorization		Full	This requirement is addressed in the UM Program Description on page 30 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 19.	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	request for service.					
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 LDH a need for additional information and how the extension is in the member's best interest.	P/P for UM P/P for post authorization		Full	This requirement is addressed in the UM Program Description on page 30 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 19.	
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.	P/P for UM P/P for post authorization		Full	This requirement is addressed in the UM Program Description on page 31 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 20. In addition, Healthy Blue provided quarterly Authorization summary reports as evidence.	
8.5.3.2	The MCO shall not subsequently retract its 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.	P/P for UM P/P for post authorization		Full	This requirement is addressed in the UM Program Description on page 31 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 20.	
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.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in the UM Program Description on page 32 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 20. **File Review Results** Ten (10) of 10 files were compliant.	
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	P/P for UM P/P for notice timing		Full	This requirement is addressed in the UM Program Description on page 32 and the Concurrent Review (Telephonic and On-Site)	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.				and On-site Review Protocol Process-LA on page 20.	
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.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in the UM Program Description on page 32 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 20. **File Review Results** Ten (10) of 10 files were compliant.	
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or reauthorization or to authorize or reauthorize 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 written notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in the UM Program Description on page 32 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 21. **File Review Results** Ten (10) of 10 files were compliant.	
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	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in the UM Program Description on page 34 and the Concurrent Review (Telephonic and On-Site)	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.				and On-site Review Protocol Process-LA on page 21.	
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)].	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in the UM Program Description on page 34 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 21. In addition it is included in the Informal Reconsideration and Peer-to-Peer – LA policy on page 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.	P/P for UM P/P for informal reconsideration P/P for notice timing Includes Informal Consideration File Review		Full	This requirement is addressed in the UM Program Description on page 34 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 21. In addition it is included in the Informal Reconsideration and Peer-to-Peer – LA policy on page 1. **File Review Results** Ten (10) out of 10 informal consideration files were compliant	
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.	P/P for UM P/P for informal reconsideration P/P for notice timing		Full	This requirement is addressed in the UM Program Description on page 34 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on page 22. In addition it is included in the Informal Reconsideration and Peer-to-Peer – LA policy on page 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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the UM Program Description on page 26 and 29 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process-LA on	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					page 14. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the UM Program Description on page 26 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 14. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the UM Program Description on page 26 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 14. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 8.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the UM Program Description on page 26 and the Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 14. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 8.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 15. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 8.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 15. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
8.5.4.2	The MCO shall not require a PCP referral for in-	P/P for UM		Full	This requirement is addressed in Concurrent	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	network eye care and vision services.	P/P for exceptions			Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 15. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 15. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
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.	P/P for UM P/P for exceptions		Full	This requirement is addressed in Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 15. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	P/P for UM P/P for exceptions		Full	This requirement is addressed in Concurrent Review (Telephonic and On-Site) and On-site Review Protocol Process- LA on page 16. In addition it is included in the Pre-Certification of Requested Services – LA policy on page 7.	
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 LDH, for purposes of making medical necessity determinations.	P/P for UM		Full	This requirement is addressed in Pre-Certification of Requested Services – LA policy on page 1. It is also addressed in the Clinical Information for Utilization Management Reviews – Core Process-LA policy on page 3 and in the Provider Manual on page 57.	
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.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in Pre-Certification of Requested Services – LA policy on page 1. It is also addressed in the Clinical Information for Utilization Management Reviews – Core Process-LA policy on page 3 and in the Provider Manual on page xx	
8.11.3	Providers who do not provide requested medical information for purposes of making medical	P/P for UM Provider Manual/Handbook		Full	This requirement is addressed in Pre-Certification of Requested Services – LA	

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Provider contracts			policy on page 1. It is also addressed in the Clinical Information for Utilization Management Reviews – Core Process-LA policy on page 3 and in the Provider Manual on page 80.	
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 LDH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in Pre-Certification of Requested Services – LA policy on page 2.	
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 analyze utilization data to identify utilization and/or quality of care issues.	PCP/BN profiling report		Full	This requirement is addressed in the UM Program Description on pages 11, 12, 14, and 48. It is also addressed in the Standards and Measures Monitoring Appropriate Accessibility to Care – LA policy and Quality of Care Core Procedure. Healthy Blue provided several reports detailing their monitoring efforts.	
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	P/P for UM		Full	This requirement is addressed in the UM Program Description on pages, 14, and 48. It is also addressed in the Standards and Measures Monitoring Appropriate Accessibility to Care – LA policy and Quality of Care Core Procedure. Healthy Blue provided several reports detailing their monitoring efforts.	
8.13	**Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay**					
8.13.1	All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.	Evidence of timely submission of profile reports		Full	This requirement is addressed in the Clinical Criteria for Utilization Management Decisions Core Process policy on page 11. Also provided was a redacted court ordered services medical necessity review.	

Eligibility, Enrollment, and Disenrollment

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
11.11	**Disenrollment**					
11.11.1	Disenrollment is any action taken by LDH 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 LDH or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.					
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	P/P for Member Disenrollment		Full	This requirement is addressed in the Member Disenrollment Desktop Process on page 2.	
11.11.3	**Member Initiated Disenrollment**					
11.11.3.0	A member may request disenrollment from an MCO as follows:					
11.11.3.1	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 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 LDH 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	P/P for Member Disenrollment		Substantial	This requirement is not fully communicated to members in the member handbook. Bullets 2, 4 and 7 were not specifically discussed in the handbook. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically bullets 2, 4 and 7, so members are clear on the reasons why they may disenroll from the MCO.	Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.

Eligibility, Enrollment, and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by LDH and/or its agent.					
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 LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a) (3).	P/P for Member Disenrollment		Substantial	This requirement is partially addressed on pages 1 and 60 of the member handbook. Bullet 1 and 3 were addressed in the handbook, but bullets 2 and 4 are missing. It also does not state that members can disenroll "without cause" due to the listed items. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically make reference to bullets 2 and 4 and state these requirements do not require good cause..	Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.
11.11.3.3	The member (or his/her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	P/P for Member Disenrollment		Full	This requirement is addressed in the member handbook on page 49. A telephone number is provided in the member handbook for members to contact the enrollment broker directly.	
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.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy.	
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	P/P for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment Policy.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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)).					
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 Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), LDH 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.	P/P for Member Disenrollment		Full	This requirement is addressed by the Member Disenrollment Desktop process, the Notice of Death disenrollment form and a Notice of Incarceration disenrollment form.	
11.11.4.3	The MCO may request involuntary disenrollment of a member if 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 LDH;	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy and is mentioned in the member handbook.	
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.	P/P for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the Disenrollment Policy.	
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	P/P for Member Disenrollment		Full	This requirement is addressed by the Member Disenrollment Desktop process, Notice of Death disenrollment form, a Notice of Incarceration disenrollment form and a blank Member Request for Disenrollment form.	

Eligibility, Enrollment, and Disenrollment						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.56)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	T).					
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.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy and was discussed onsite. The MCO provided a Disenrollment Procedure and Recordkeeping document to show compliance with maintaining involuntary disenrollment information in an identifiable member record.	
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of LDH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy and was discussed onsite.	
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. 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.	P/P for Member Disenrollment		Full	This requirement is addressed in the Disenrollment Policy.	

Marketing and Member Education

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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.). The MCO shall also comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i):					
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 LDH.	P/P for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2.	
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 LDH.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2.	
12.9.3	LDH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.					
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.	P/P for Written Member Materials Guidelines P/P for Disclosure of Financial Interest		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2.	

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12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	P/P for Written Member Materials Guidelines P/P for Compliance with "Person First" Policy Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2.	
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.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 1 in addition, during the onsite interview Healthy Blue discussed that they do not have a commercial product.	
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.	P/P for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2. The member handbook was provided as evidence of this contract reference.	
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;	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Interpretation Services		Full	This requirement is addressed in the Written Materials Guide-LA Procedure #3 on page 2 and the Healthy Blue New Member Welcome Booklet –Head Copy section on page 8.	
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to 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.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook, Your Providers section on page 8.	
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.	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Access to Alternative Forms of Communication		Full	This requirement is addressed in the Written Materials Guide-LA, Procedure #3 on page 2, and the Healthy Blue New Member Welcome Booklet –Head Copy section on page 8.	

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12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.					
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.	P/P for Member Education P/P for Member Disenrollment P/P for Member Enrollment P/P for Member Re-enrollment		Full	Disenrollment-LA Procedure, Plan-Initiated disenrollment on page 3. This was also addressed on page 66 of the member handbook.	
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;	Link to member portal		Full	This requirement is addressed through the Healthy Blue website (https://www.myhealthybluela.com/la/louisiana-home.html). There is also a link to download a mobile app. In addition, Healthy Blue reaches out to members through social media and provided screen shots as support.	
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;	Example of bullets/news letter		Full	This requirement is addressed through the submission of Q2 and Q4 member newsletters for review.	
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 Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Brochures and other examples of literature including EPSTD materials		Full	This requirement is addressed through the submission of the Healthy Blue Teen Wellness Flier, Well Woman Postcard, Healthy Blue 0-23 months Well Visits, and the Healthy Blue Well Visits flier.	

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12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special health care needs;	Brochures and other examples targeted to members with chronic disease/SHCN		Full	This requirement is addressed through the submission of the following documents: Healthy Blue Hepatitis C Flier, Healthy Blue Case Management Brochure, Healthy Blue Living with HIV AIDS, and Healthy Blue Living Well with Diabetes Flier.	
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials		Full	This requirement is addressed through the submission of the following materials: Healthy Blue Case Management Brochure, Healthy Blue Disease Management Programs Flier, Online Health Education screenshot, and the Health and Wellness website (https://www.myhealthybluela.com/la/care/health-wellness.html).	
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications		Full	This requirement is addressed in the Healthy Blue Member Handbook, Different Types of Healthcare on pages 40-42. Healthy Blue also provided brochures on Healthy Weight and Asthma Action Plan.	
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications		Full	This requirement is addressed in the Healthy Blue Member Handbook, Health Education Classes on page 51. Several Healthy Blue brochures on health education were also provided.	
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material		Full	This requirement is addressed through the submission of brochures on Cholesterol, Hepatitis C, Colon and Rectal Cancer, and Living Well with Diabetes. At the onsite, Healthy Blue discussed how they provide materials at health promotions such as diabetes, hypertension, and new baby promotions.	
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	Example Member education material		Full	This requirement is addressed through the submission of the Healthy Blue Member Handbook, Going to the Primary Care Provider on page 13, the Healthy Blue Colon	

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	exacerbations related to that disability or disabilities;				and Rectal Cancer Screening document, and the Healthy Blue Hepatitis C Flier.	
12.11.3.11	Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and	Notification P/P member education		Full	This requirement is addressed in the Distribution of Member Materials – LA Procedure on page 5.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P member education		Full	This requirement is addressed in the Distribution of Member Materials – LA Procedure on page 5.	
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 (g) and may use the state developed model member handbook for each of the covered populations as specified in section 3.3.3.).	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook.	
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				
12.12.1.3	A general description about how MCOs operate, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;	Member Handbook		Full	This requirement is addressed in the member handbook. The language about explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO, as required by 42 CFR §438.62, is not being required per LDH.	
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 60.	
12.12.1.5	Member's right to select and change PCPs within	Member Handbook		Full	This requirement is addressed in the Healthy	

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	the MCO and how to do so;				Blue Member Handbook on page 9.	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 10.	
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 66-67.	
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and LDH 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		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 14-28.	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 38.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 6.	
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 17.	
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;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 41.	

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	• 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.					
12.12.1.13	The post-stabilization care services rules set forth in 42 CFR 422.113(c);	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 64.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 10.	
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 LDH;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 37.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 53.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 63.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 56 and 58.	
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: o The right to a hearing; o The method for obtaining a hearing; and o The rules that govern representation at	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 54-59.	

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	the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing 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: o Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and o 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 LDH who has final authority to determine whether services must be provided.					
12.12.1.20	Advance Directives, set forth in 42 CFR §438. 10 (g)(2) (xii) - 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	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 53 and 54.	

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	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.					
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana 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;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 3.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 11 and 12.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 2.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 5.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook in the Schedule a Wellness Checkup With Your Doctor Now! section.	
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 an auto accident;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 65.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 61.	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 65.	

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	deemed essential by the MCO or LDH. 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;					
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 3.	
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		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 60.	
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to LDH and MCO toll-free numbers and website established for that purpose;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 8.	
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 61.	
12.12.1.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on the cover page.	
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 438.3 (i)]. Service utilization policies; and How to report alleged marketing violations to LDH utilizing the Marketing Complaint Form.	Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 66.	
12.12.1.35	Information regarding specialized behavioral health services, including but not limited to: • 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	Member handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on pages 3-5 and 27-37.	

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	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.					
12.12.1.36	Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;	Member handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 61.	
12.12.1.37	The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:	Member handbook		Full	This requirement is addressed through the distribution of the Healthy Blue Member Handbook, New Member Welcome Packet, and the Distribution of Member Materials-LA Procedure on page 2.	
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;			Full	This requirement is addressed through the mailing of the Healthy Blue New Member Welcome Booklet.	
12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;			Full	This requirement is addressed in the Distribution of Member Materials-LA Procedure on page 2.	
12.12.1.37.3	Posts the information on their member website and advises the member in paper or electronic form that the information is available at the specified web address; or			Full	This requirement is addressed in the Healthy Blue New Member Welcome Booklet.	
12.12.1.37.4	Provides the information in any other method that can be reasonably expected to result in the member receiving the information.			Full	This requirement is addressed in the Healthy Blue New Member Welcome Booklet.	

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12.12.1.38	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.	Member notification		Full	This requirement is addressed in the Standing Annual member Notification Policy.	
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook		Full	This requirement is addressed in the Developing and Revising Member Handbooks Policy.	
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	P/P for Provider Directory Provider Directory		Full	This requirement is addressed in the Provider Directories Policy.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	P/P for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed through the submission of the hardcopy provider directory.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)		Full	This requirement is addressed through the web URL that was submitted for the provider directory. **Final Review Determination** This requirement was changed to Full based on the MCO response. Upon reviewing the initial provider directory screenshot there was a link to a machine readable web page.	There is link in the footer of the Healthy Blue "Find a Doctor" webpage that links you to the page where the machine readable file is posted. This file is refreshed on a daily basis when the overall data for the site is refreshed: http://healthybluela.prismisp.com/JSONFiles/HealthyBlueLA-Providers-Louisiana.json 12 (See evidence "Provider Directory Website")
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	P/P for Provider Directory Provider Directory (electronic file format)		Full	This requirement is addressed in the Provider Directories Policy and the submission of screenshots showing file uploads.	
12.14.1.4	Hard copy, abbreviated version upon request by	P/P for Provider Directory		Full	This requirement is addressed in the Provider	

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	the Enrollment Broker.	Provider Directory (abbreviated hard copy)			Directories Policy.	
12.14.3	The hard copy directory for members shall be reprinted with updates at monthly or no more than 30 days after the receipt of updated provider information. 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 LDH.	P/P for Provider Directory		Full	This requirement is addressed in the Provider Directories Policy.	
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, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Substantial	This requirement is partially addressed in the Provider Directories Policy and submission of the hard copy directory as well as the web link. However, website URLs and the providers cultural competency training are not included. **Recommendation** Healthy Blue should include both the website URL and the provider's cultural competency training in their directory. **Final Review Determination** No change in findings. While the website does contain the provider URL and cultural competency information when available, this	Healthy Blue includes the website URL (if the provider has one), as well as cultural competency training in the provider directory. (See evidence "Provider Directory Website_2")

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					requirement is for the hard copy directory which does not contain this information.	
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;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the Provider Directories Policy and submission of the hard copy directory, as well as the web link.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the Healthy Blue Member Handbook on page 64.	
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).	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the web directory search on the website.	
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.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the following documents: Member Rights and Responsibilities – LA Policy; Healthy Blue Member Handbook, Your Rights and Responsibilities as a Healthy Blue Member on page 62, and the Provider Manual in section 2.33, Healthy Blue Member Rights and Responsibilities.	
12.15.2	Members Rights. The rights afforded to current	P/P for Member Rights and		Full	This requirement is addressed in the Healthy	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	members are detailed in Appendix AA, Members' Bill of Rights.	Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract			Blue Member Handbook, Your Rights and Responsibilities as a Healthy Blue Member on page 62.	
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.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the Healthy Blue Member Handbook, Your Rights and Responsibilities as a Healthy Blue Member on page 62.	
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	P/P for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed in the Healthy Blue Member Handbook, Your Rights and Responsibilities as a Healthy Blue Member on page 62.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 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.	P/P for Provider Termination P/P for notifying members of provider termination		Full	This requirement is addressed through the Timely Notification of Participating Providers – LA Procedure on page 6 and the PCP Termination Letter.	
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	P/P for Provider Termination P/P for notifying members of provider termination		Full	This requirement is addressed through the Timely Notification of Participating Providers – LA Procedure on page 6 and the PCP Termination Letter.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.					
12.19	**Oral Interpretation and Written Translation Services**					
12.19.1	In accordance with 42 CFR §438.10(d) LDH 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 not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in the Culturally and Linguistically Appropriate Services, CLAS Notification to members on page 5; Telephonic Interpreter Services on page 5, and the Healthy Blue Member Handbook, Healthy Blue Member Services, page 3, Language Assistance, page 4, and Get Oral Interpretations, page 64.	
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 LDH, 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).	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services		Full	This requirement is addressed in the Culturally and Linguistically Appropriate Services, Alternate, Appendix, Alternative Communication Formats, page 7; LA Appendix, page 28; Written Materials Guidelines – LA Procedure # 5, pages 2-3; Healthy Blue Member Handbook, Healthy Blue Member Services, page 3; Language Assistance, page 4; and Your Rights and Responsibilities, page 64.	
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request	P/P for Member Rights and Responsibilities		Full	This requirement is addressed in the Member Rights and Responsibilities – LA Policy on pages 3 and 6.	

Marketing and Member Education						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.10, 438.100)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.					

Member Grievance and Appeals

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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. The MCO shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy and the Member Appeals – Core Process Policy.	
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.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in Member Appeals – Core Process Policy on pages 1 and 14.	
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.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in Member Appeals – Core Process Policy on page 13.	
13.2.3	**Time Limits for Filing** The member shall be permitted to file a grievance at any time. The member must be allowed sixty (60) calendar days from the date on the MCO's notice of action or inaction to request an appeal.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy on page 6.	
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in	P/P for Grievances		Full	This requirement is addressed in the Member Complaints and Grievances – LA	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	writing with either LDH or the MCO.				Policy on page 5.	
13.2.4.2	The member or provider may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.	P/P for Appeals P/P for Fair Hearing		Substantial	This requirement is partially addressed in the Member Appeals – Core Process LA Policy. **Recommendation** The MCO should finalize updated policy to include new language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy page 2 of 16
13.2.4.3	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 paper copies must be provided by the MCO upon request of the member. The MCO shall make all forms easily available on the MCO's website.	P/P for Grievances P/P for Appeals P/P for Fair Hearing		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy and the Member Appeals – Core Process Policy. In addition, it is in the member handbook in the Grievances section starting on page 54.	
13.3	**Grievance/Appeal Records and Report**					
13.3.1	The MCO must maintain accurate records of all grievances and appeals in a manner accessible to LDH and available upon request to CMS. A copy of grievances logs and records of disposition of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy on page 5 and the Member Appeals – Core Process – LA Policy on page 10.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	which arise from it or until the end of the regular ten (10) year period, whichever is later.					
13.3.2	The MCO shall electronically maintain data on grievances/appeals in accordance with the requirements outlined in this section, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action.	P/P for monthly reporting of grievances and appeals including sample report format		Full	This requirement is addressed through the submission of monthly regulatory grievance reports.	
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.	P/P for Adverse Decisions		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy on page 6.	
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;	P/P for Grievances P/P for Appeals Acknowledgement Letter Template Includes Member Grievance File and Member Appeal File Review		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy on page 7. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant. **Appeal File Review Results** Ten (10) of 10 appeals files reviewed were	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					compliant.	
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;	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Appeals – Core Process, Policy on page 9 and the Member Complaints and Grievances – LA Policy on page 5.	
13.4.1.3 13.4.1.3.1 13.4.1.3.2 13.4.1.3.3	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; nor a subordinate of any such individual; • who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by LDH, in treating the member's condition or disease: o an appeal of a denial that is based on lack of medical necessity, o a grievance regarding denial of expedited resolution of an appeal, o a grievance or appeal that involves clinical issues. • Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.	P/P for Grievances P/P for Appeals Includes Member Grievance File and Member Appeal File Review		Full	This requirement is addressed in the Member Appeals – Core Process on page 6 and the Member Complaints and Grievances – LA Policy on page 12. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant for not being involved in any previous level of review or decision-making. Fifteen (15) of 15 grievance files were N/A for reviewer being a health care professional with appropriate expertise since these were administratively related. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant for not being involved in any previous level of review or decision-making. Ten (10) of 10 appeals files reviewed were compliant for reviewer being a health care professional with appropriate expertise since these were administratively related.	
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 appeal). The member, member's authorized representative or provider, acting on behalf of the member and with	P/P for Appeals Member Handbook Confirmation Letter Template		Full	This requirement is addressed in the Member Appeals – Core Process on page 2 and the member handbook on page 57.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	the member's written consent, may file an expedited appeal either orally or in writing. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.					
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 sufficiently in advance of the date by which the MCO shall resolve the appeal in the case of expedited resolution).	P/P for Appeals Member Handbook Process for notifying member of opportunity to provide evidence Includes Member Appeals File Review		Full	This requirement is addressed in the Member Appeals – Core Process – LA, Policy on page 1 and the member handbook on - page 67. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
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 and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal.	P/P for Appeals Member Handbook Process for notifying member of opportunity to examine case file Includes Member Appeals File Review		Full	This requirement is addressed in the Member Appeals — Core Process – LA Policy on page 1 and the member handbook page on 55. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
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.	P/P for Appeals Member Handbook Includes Member Appeals File Review		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 1 and the member handbook page on 55. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
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.	Training Agendas and attachments Sign-in sheets		Full	This requirement is addressed in the Member Complaints and Grievances — LA, Procedure as well as the training PowerPoint that was provided as evidence.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
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.	Name and title of individual or name of body having decision-making authority Job description for individual having decision-making authority		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 11.	
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, the member's request will be deemed to exhaust the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.	P/P for Appeals		Substantial	This requirement is partially addressed in the Member Appeals– Core Process – LA Policy on page 4. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, number 5, page 4 of 16
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.	P/P for Appeals P/P for Fair Hearing Appeal Resolution Notice		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on pages 9 and 14.	
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 and Section 12 of this RFP to ensure ease of understanding.	Notice of Action Includes Member Grievance File And Member Appeal File Review		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy on page 12. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					compliant.	
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;	P/P for Notice of Action Notice of Action Includes Member Grievance File and Member Appeals File Review		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy on pages 21 to 23. **Grievance File Review Results** Fifteen (15) of 15 grievance files reviewed were compliant. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.5.2.2	The reasons for the action; including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy on pages 21 to 23. **Appeals File Review Results** Fifteen (15) of 15 appeals files reviewed were compliant.	
13.5.2.3	The member's right to file an appeal with the MCO;	P/P for Notice of Action Notice of Action Review		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy on pages 21 to 23.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on pages 9 and 14. **Appeals File Review Results** Eight (8) of 8 appeals files reviewed were compliant. Two (2) of 2 appeals files reviewed were N/A as the appeal was upheld in the member's	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					favor.	
13.5.2.5	The procedures for exercising the rights specified in this section;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Member Appeals— Core Process– LA Policy on pages 9 and 14.	
13.5.2.6	The circumstances under which expedited appeal is available and how to request it;	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Member Appeals — Core Process – LA Policy on page 2 and the member handbook on page 57.	
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, 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	P/P for Notice of Action Notice of Action Includes Member Appeal File Review		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 13 and the member handbook on page 58. **Appeals File Review Results** Eight (8) of 8 appeals files reviewed were compliant. Two (2) of 2 appeals files reviewed were N/A as the appeal was upheld in the member's favor.	
13.5.2.8	Availability of interpretation services for all languages and how to access them.	P/P for Notice of Action Notice of Action		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 9 and the member handbook on page 64.	
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,:	P/P for Notice of Action		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy, Notice of Action on page 20.	
13.5.3.2	In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud at least five (5) days before the date of action;	P/P for Notice of Action		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy, Notice of Action on page 20.	
13.5.3.3	By the date of action for the following: • In the death of a recipient;	P/P for Notice of Action		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• If the member submits 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 • As otherwise permitted under 42 CFR §431.213.				Policy, Notice of Action on page 20.	
13.5.3.4	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.	P/P for Notice of Action		Full	This requirement is addressed in the Claims Payment Appeal Management – LA Policy.	
13.5.3.5 13.5.3.5.1 13.5.3.5.2	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.	P/P for Notice of Action P/P for Notice of Action for Standard Service Authorizations P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA on page 8.	
13.5.3.6	If the MCO extends the timeframe in accordance with above, it must: • Make reasonable efforts to give the member prompt oral notice of the delay;	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Member Appeals - Core Process- LA Policy on page 4 and the UM Extension Desktop Process Procedure.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• Within two (2) days, 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.	Includes Member Appeal File Review			**Appeals File Review Results** There were no extended appeals in the sample files reviewed.	
13.5.3.7	On the date the timeframe for service authorization as specified expires. Untimely service authorizations constitute a denial and are thus adverse actions.	P/P for Notice of Action		Full	This requirement is addressed in the Health Care Management Denial Core Process – LA Policy on page 8 and the UM Extension Desktop Process Procedure.	
13.5.3.8	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the 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.	P/P for Notice of Action P/P for Notice of Action for Expedited Service Authorizations		Full	This requirement is addressed in the Pre-Certification of Requested Services – LA Policy on page 5.	
13.5.3.9	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.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Pre-Certification of Requested Services – LA Policy on page 5.	
13.5.3.10	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	P/P for Grievances P/P for Appeals		Full	This requirement is addressed in the Member Complaints and Grievances – LA	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	as the member's health condition requires, within the timeframes established below.				Policy on page 7 and the Member Appeals – Core Process – LA Policy on page 3.	
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.	P/P for Grievances Includes Member Grievance File Review		Full	This requirement is addressed in the Member Complaints and Grievances – LA Policy on page 7 and the member handbook, Medical Appeals, on page 56. **<u>File Review Results</u>** Fifteen (15) of 15 grievance files reviewed were compliant.	
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.	P/P for Appeals Includes Member Appeals file review		Substantial	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 3 and the member handbook, Grievances and Medical Appeals, on page 55. **<u>Appeals File Review Results</u>** Eight (8) of 10 appeals files reviewed were compliant. **<u>Recommendation</u>** The MCO should ensure that appeals are resolved according to contractual requirements of 30 days.	Staff training was conducted with ongoing monthly monitoring by internal accreditation staff.
13.6.1.3	**Expedited Resolution of Appeals** 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.	P/P for Appeals Includes Member Appeals File Review		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 3 and the member handbook, Grievances and Medical Appeals, on page 57. **<u>Appeals File Review Results</u>** Ten (10) of 10 appeals files reviewed were NA as there were no expedited appeals in the sample.	
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	P/P for Appeals P/P for Grievances P/P for Handling Extensions		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 4 and the member handbook,	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	(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.	Notice of Decision to Extend Timeframe Includes Member Appeals File Review			Grievances and Medical Appeals, on page 55. **Appeals File Review Results** Two (2) of 2 appeals files reviewed were compliant. Eight (8) files were NA.	
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. • Within two (2) calendar days 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. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeals File Review		Substantial	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 14. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Appeals File Review Results** Two (2) of 2 appeals files reviewed were compliant. Eight (8) files were NA. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Member Appeals – Core Process Policy, Extending Decision Timeframe, page 13-14 of 16
13.6.3	In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.	P/P for Appeals		Substantial	Member Appeals – Core Process – LA Policy on page 9. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination**	Member Appeals – Core Process Policy, number 5, page 4 of 16

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	
13.6.4 13.6.4.1 13.6.4.2	**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.	P/P for Grievances P/P for Appeals Resolution Notice		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 9.	
13.6.5 13.6.5.1 13.6.5.2	**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 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.	P/P for Appeals Resolution Notice		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 13. It is also addressed during the review of the Notice of Appeal Resolution letter file review.	
13.6.6	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.					
13.6.6.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within one hundred twenty (120) days from the date of the MCO's notice of resolution. The member may also initiate a State Fair Hearing following deemed exhaustion of appeals processes.	P/P for Appeals P/P for Fair Hearings		Full	This requirement is addressed in the Member Appeals— Core Process – LA Policy on page 9.	
13.6.6.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or	P/P for Fair Hearings		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	her representative or the representative of a deceased member's estate.				on page 9.	
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.	P/P for Appeals		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 2.	
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 written consent, who requests an expedited resolution or supports a member's appeal.	P/P for Appeals Provider Handbook		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 9.	
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.	P/P for Appeals Denial Notice		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 4.	
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above	P/P for Appeals		Substantial	This requirement is partially addressed in the Member Appeals –Core Process – LA Policy	Member Appeals – Core Process Policy, number 5,

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have exhausted the MCO's appeal process as of the date upon which a final determination should have been made.				on page 4. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	page 4 of 16
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. No additional follow-up may be required.	P/P for Appeals		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 2.	
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.	Process for notifying member of opportunity to present evidence		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 2. Also provided were the Appeal Acknowledgement and Member Appeal Verbal Acknowledgement Letter as evidence.	
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.	P/P for Appeals		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 3.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	P/P for Appeals Includes Member Appeal		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 4.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
		File Review			**Appeals File Review Results** There were no expedited appeals in the sample of files reviewed.	
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 in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii); • 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 benefits.	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Member Appeals — Core Process – LA Policy on page 13 and the member handbook on page 59.	
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;	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 13 and the member handbook on page 58.	

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• 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.					
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).	P/P for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Member Appeals – Core Process — LA Policy on page 13 and the member handbook on page 58.	
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)(2)(xi) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Manual/Handbook Provider Contract Contractor Contract		Full	This requirement is addressed in the provider manual and provider model contract.	
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.	P/P for Grievances P/P for reporting grievances and resolutions to DHH Report Format		Full	This requirement is addressed through the submission of the monthly grievance reports and proof of submission documents.	
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 but no later than 72 hours from the date it receives notice reversing the decision..	P&P for effectuation of reversed appeal resolutions		Substantial	This requirement is addressed in the Member Appeals – Core Process — LA Policy on page 13. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language.	Member Appeals – Core Process Policy, Continuation of Benefits, page 12-13 of 16

Member Grievance 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)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					Final Review Determination No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	
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.	P&P for effectuation of reversed appeal resolutions		Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 13.	

Quality Management

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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 §438.330(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;	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 6, in the 2019 Healthy Blue QM PD description with Appendices on pages 5 and 6, and in the 2018 and 2019 Medicaid QM Work Plans.	
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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 19, in the 2019 Healthy Blue QM PD with Appendices on page 19, and in the 2018 and 2019 Medicaid QM Work Plans.	
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 19, in the 2019 Healthy Blue QM PD with Appendices on page 19, and in the 2018 and 2019 Medicaid QM Work Plans.	
14.1.6	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 LDH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 22, in the 2019 QM Program Description with Appendices A to F on page 21, and in the Healthy Blue PA Provider Notices – entire document.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
14.1.7	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 and other disorders for children under age 6.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the Healthy Blue Prematurity PIP, the PCIT Training Workshop Schedule for HB, the Healthy Louisiana ADHD PIP Q1 2019, and in the LARCProviderNotice _ProviderWebsite documents.	
14.1.8	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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the ADHD Single PDL document,	
14.1.9	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 16, in the 2019 QM Program Description with Appendices on page 21, with implementation addressed in the CSoC report, the report on children in restrictive settings, and the DCSF QOC Referral from CM to QM.	
14.1.10	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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 22 and in the 2019 QM Program Description with Appendices on page 21.	
14.1.11	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	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 11 and in the 2019 QM Program Description with Appendices on page 11.	

Quality Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of LDH.					
14.1.12	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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final, Key Program Initiatives on pages 12-19, in the 2019 QM Program Description with Appendices on pages 11-18, and in the IET PIP proposal.	
14.1.13	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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on pages 12-19 and in the 2019 QM Program Description with Appendices on pages 11-18.	
14.1.15	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's 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.	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the 2018 Healthy Blue QM PD Final on page 9 and in the 2019 QM Program Description on page 9.	
14.1.16	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.	Feedback reports QAPI work plan		Full	This requirement is addressed in the 2018 QM Program Description on page 15, the 2019 QM Program Description on page 59, the Barrier Analysis Interviews Combined, the 2018 Louisiana Medicaid Consumer Needs, and the 2018 Healthy Blue HEAC Plan on page 2.	
14.1.17	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH.	Evidence of submission to LDH		Full	This requirement is addressed in the Healthy Louisiana IET PIP Proposal, the Healthy Louisiana ADHD Interim PIP, the Healthy Louisiana ADHD PIP Q1 2019 quarterly Data Report, and in the Collaborative Prematurity PIP PDSA Worksheet HealthyBlueLA.pdf.	
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice	Clinical guidelines for ADHD Provider education		Full	This requirement is addressed in the ADHD Provider Training document, the	

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	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.	Provider manual			LALA_CAIDCPG_Matrix, the ADHD CPG American Academy of Pediatrics, the BLAPEC-0937-18 State ADHD Toolkit Web Post Final, and the Healthy Louisiana ADHD PIP Q1 2019 Quarterly Data Report.	
14.1.19	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	P/P provider oversight Peer review reports		Full	This requirement is addressed in the Peer Review-LA Policy and Procedure, with implementation addressed in the ad hoc April 2019 minutes of the Credentials Committee..	
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets		Substantial	This requirement is addressed in the Intervention Tracking Measure (ITM) Workgroup meeting notes for March 21, 2019, and in the Quality Meeting Participation document. The MCE submitted PDSA worksheets and run chart for all ITM workgroup meetings, except for the meeting on October 4, 2018, which the plan did not attend due to all PIP staff attending the NCQA Conference, with advance notice to IPRO and LDH on 9/20/18. **Recommendation** Healthy Blue should ensure that at least one representative is available to attend all PIP meetings, and submit all requested monitoring documentation for each meeting.	Healthy Blue will ensure that a representative is present at all IMT and QM meetings moving forward and documentation is submitted.
14.1.21	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	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH		Full	This requirement is addressed in the 329 HBL Report Q1 2019, the 313 HBL Reports Q1 2019, the 333 Strategy Report-Healthy Blue 2019, and the 333 Strategy Report LDH Upload.	

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	children receiving CSoC services and EBPs.					
14.1.21.1 14.1.21.2	.1 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. .2 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 LDH-OBH on an annual base.	Outcome measures and results BH outcome measures and evidence shared with LDH		Full	This requirement is addressed in the 355 HBL 20018 SA2 Resubmit 1 (002) Report for provider delivery of behavioral services and in the 333 Strategy Report-Healthy Blue 2019 for member outcomes.	
14.2	**QAPI Committee**					
14.2.1	The MCO shall form a QAPI Committee that 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;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the 2018 QM Program Description Appendices A to F on page 3 and in the 2019 QM Program Description with Appendices on page 25.	
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the in the 2019 QM Program Description with Appendices on page 25.	
14.2.1.3	Appropriate MCO staff representing the various departments of the organization will have membership on the committee;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the in the 2019 QM Program Description with Appendices on page 25.	
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 9, with implementation addressed in the HEAC Q3 2018 meeting minutes and roster. The Health Education Advisory Committee (HEAC) reports up to QAPI.	
14.2.1.5	The MCO shall include LDH representative(s) on the QAPI Committee, as designated by LDH as non-voting member(s).	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the in the 2019 QM Program Description with Appendices on page 25 (page 3 of Appendices).	
14.2.2	**QAPI Committee Responsibilities**	QAPI Program Description		Full	This requirement is addressed in the	

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	The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Work Plan QAPI Committee Description including roles and responsibilities			2019 QM Program Description with Appendices on page 25.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 25.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 25.	
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 25.	
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 25.	
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 19 as part of the overall QM Program, and on page 25 as a responsibility of the QAPI Committee.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description		Full	This requirement is addressed in the Provider Summary Report Card and in the QMC Meeting 02.08.19 Minutes.pdf.	
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description with Appendices on page 19 as part of the overall QM Program, and in the Quality Management Dashboard Q1 2019, which the MCO indicated is presented to the Plan Compliance Committee quarterly.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description		Full	The analysis requirement is addressed in the 2019 QM Program Description with Appendices on page 21 and in the QMC Meeting 09.21.18 Minutes.pdf on page 4.	
14.2.2.9	Maintain minutes of all committee and sub-	QAPI Program Description		Full	This requirement is addressed in the Quality	

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	committee meetings and submit meeting minutes to LDH;				Management Committee Notes for Q2 2018, Q3 2018, Q4 2018, and Q1 2019 with documentation of submission to LDH.	
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management services;	QAPI Program Description		Full	This requirement is addressed in the 2018 QM Eval_QMC and in the 2019 QM Program Description with Appendices on page 21.	
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description		Full	This requirement is addressed in the LA Quality Management Committee meeting minutes dated December 17, 2018, and in the document 119 HBL 2018 Q4.	
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Program Description		Full	This requirement is addressed in the BLA-PM-0006-18 LA Medicaid Provider Manual Update Final No cover and in the Provider Manual Update Review document that indicates QAPI Committee Chair reviewed the update.	
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 LDH 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:	QAPI Program Description QAPI Work Plan Evidence of timely submission of the written QAPI plan		Full	This requirement is addressed in the 2019 Medicaid QM Work Plan. The plan also provided 136 HBL 2018 Submission as evidence of document upload to LDH, with submission documented in the 136 HBL 2018 Submission document.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QAPI Program Description		Full	This requirement was addressed in the 2019 QM Program Description Appendices A to F on pages 8-9.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 8-9.	
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;	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 9-10.	
14.2.3.4	Describe the role of its providers in giving input to	QAPI Program Description		Full	This requirement is addressed in the 2019	

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	the QAPI Program; and				QM Program Description Appendices A to F on pages 42-43.	
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.	QAPI Program Description		Full	This requirement is addressed in the 2019 QM Program Description Appendices A to F document; however, multiple pages have mixed references to Healthy Blue and Anthem members, for example, on page 3, both are mentioned in the first paragraph under the heading, "Culturally Appropriate Care." In response to EQRO request for explanation, the plan asserts that, "The Program Description documentation is unique to Healthy Blue and its membership. The MBHO and CLAS certifications are Anthem certifications with state-specific elements in which Healthy Blue voluntarily participates in."	
14.2.3.6	Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	QAPI program description		Substantial	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11 regarding data collection, and in the HEDIS Administration Process Policy and Procedure regarding HEDIS measures, as well as reliability for manual chart abstraction; however, the methods the plan uses to ensure data validity and reliability for Intervention Tracking Measures used for PDSA QI are not described. In response to EQRO request for documentation, the MCO submitted the 17-P Involan summary screen shot, which shows the logic for the retrospective annual 17-P measure but not for the concurrent monthly ITMs used to monitor CM outreach, engagement, and facilitation. On-site, the plan explained how the CM data	Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process.

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					used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **Recommendation** The MCO should continue with their plan to improve data integrity.	
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.	Monitoring plan		Full	This requirement is addressed in the Healthy Blue Fidelity Monitoring Plan 2019.	
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to LDH 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.	QAPI Program Description		Full	This requirement is addressed in the 2018 QM Eval QMC document, the 136 HBL 2018 document and corresponding HBL 136 2018 Submission document, as well as the 2018 QM Eval_QMC approved 29 Mar 19.	
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 LDH using the specifications and format approved by LDH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and LDH.	QAPI Program Description		Full	This requirement is addressed in the 329 HBL Q1 report and corresponding submission document for children in restrictive settings, and in the 313 HBL 2019 Q1 report and corresponding submission document for specialized behavioral health.	
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report on performance measures listed in Attachment E and in accordance with the timeline and format specified in the MCO Quality Companion Guide.	HEDIS IDSS results PM results		Full	This requirement is addressed in the IDSS MY2017 Submission report.	
14.2.5.2	The MCO shall have processes in place to monitor and self-report all performance measures.	P/P performance measures Final audit report		Full	This requirement is addressed for HEDIS measures in the HEDIS Administration Process document on pages 2 and 7.	

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14.2.5.3	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	P/P performance measurement		Full	This requirement is addressed in the Provider Summary Report Card.	
14.2.5.4	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	P/P QAPI program description		Full	This requirement is addressed in the 2019 QM Program Description Appendices A to F on page 10.	
14.2.5.5	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.	P/P QAPI program description		Full	This requirement is addressed in the 2019 QM Program Description Appendices A to F on page 11, and is supported by the ITM Workgroup meeting minutes.	
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan		Substantial	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11, and the 17-P Inovalon summary screen shot presents the logic for the annual 17P performance measure, which is also supported by the HEDIS Administration Process policy on page 7; however, pertinent to contractual requirement 14.2.5.2, the similarity between the monthly ITM denominator to measure pregnant women with a prior preterm birth and the annual 17P denominator merits supporting documentation and explanation of the accuracy of these measures. On-site, the plan explained how the CM data used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **Recommendation** The MCO should continue with their plan to improve data integrity.	Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process.
14.2.5.7 14.2.5.7.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Attachment E annotated with "$$".	HEDIS results – incentive measures		Full	This requirement is addressed in the IDSS MY2017 Submission report.	

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14.2.5.7.2	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 LDH's established benchmarks for improvement.					
14.2.5.7.3	LDH 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 LDH will provide six (6) months' notice of such change.	P/P Performance measures		Not applicable		
14.2.5.8 14.2.5.8.1	**Performance Measures Reporting** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	HEDIS results IDSS submission Final audit report				
14.2.5.8.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by LDH.			Full	This requirement is addressed in the Healthy Blue Prematurity Final PIP Report.	
14.2.5.8.3	The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.2.5 Performance Measures.	P/P performance measures		Full	This requirement is addressed in the HEDIS Administration Process Policy and Procedure.	
14.2.5.9	Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).	P/P performance measures		Full	This requirement is addressed in the DTS Group HEDIS Final Audit Report.	
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 §438.330.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Study Selection Design Implementation and Evaluation QIP PIP Policy and Procedure on page 10, and implementation is addressed in the Healthy Louisiana IET PIP Proposal, the Healthy Blue Prematurity PIP Final PIP Report, and in the Healthy Blue ADHD Interim PIP Report, with additional	

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					supporting documentation in the Prematurity PIP Workgroup Minutes 1 and 2.	
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. LDH may require up to two (2) additional projects for a maximum of four (4) projects.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Healthy Louisiana IET PIP Proposal, the Healthy Blue Prematurity PIP Final PIP Report, and in the Healthy Blue ADHD Interim PIP Report, with additional supporting documentation in the Prematurity PIP Workgroup Minutes 1 and 2.	
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional LDH-approved behavioral-health PIP each contract year.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Study Selection Design Implementation and Evaluation QIP PIP Policy and Procedure on page 10, and implementation is addressed in the Healthy Louisiana IET PIP Proposal and in the Healthy Blue ADHD Interim PIP Report.	
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 interventions to achieve improvement in the access to and quality of care; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Healthy Louisiana IET PIP Proposal, the Healthy Blue Prematurity PIP Final PIP Report, and in the Healthy Blue ADHD Interim PIP Report, with additional supporting documentation in the Prematurity PIP Workgroup Minutes 1 and 2.	
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 LDH for approval. The detailed description shall include:	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Healthy Louisiana IET PIP Proposal, the Healthy Blue Prematurity PIP Final PIP Report, and in the Healthy Blue ADHD Interim PIP Report.	

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	• An overview explaining how and why the project was selected, the status of the PIP, and 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; • 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	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the Prematurity PIP Final PIP Report, with additional supporting documentation in the Prematurity PIP Workgroup Minutes 1 and 2, the Prematurity PIP Run Charts, and in the Collaborative Prematurity PIP PDSA Worksheet Healthy Blue.	

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	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 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.	CAHPS report		Full	This requirement is addressed in the 2018_Anthem Adult- Healthy Blue (LA)_AM_CAHPS Report and Cross Tabs and in the 2018_Anthem - Healthy Blue (LA)_CMCCC_CAHPS Report and Crosstabs.	
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 Vendor contract		Full	This requirement is addressed in the DSS Research SOW_CAHPS Statement of Work.	

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	CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.					
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS report		Full	This requirement is addressed in the 2018_Anthem Adult- Healthy Blue (LA)_AM_CAHPS Report and Cross Tabs and in the 2018_Anthem - Healthy Blue (LA)_CMCCC_CAHPS Report and Crosstabs.	
14.2.10.5	The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses will be aggregated by LDH 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.	CAHPS data file		Full	This requirement is addressed in the 2018_Anthem Adult- Healthy Blue (LA)_AM_CAHPS Report and Cross Tabs and in the 2018_Anthem - Healthy Blue (LA)_CMCCC_CAHPS Report and Crosstabs.	
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used		Full	This requirement is addressed in the DSS Research SOW_CAHPS Statement of Work.	
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS reports		Full	This requirement is addressed in the 2018_Anthem Adult- Healthy Blue (LA)_AM_CAHPS Report and Crosstabs and in the 2018_Anthem - Healthy Blue (LA)_CMCCC_CAHPS Report and Crosstabs.	
14.2.10.8 14.2.10.8.1 14.2.10.8.2 14.2.10.8.3 14.2.10.8.4 14.2.10.8.5	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: .1 Getting Needed Care, .2 Getting Care Quickly, .3 How Well Doctors Communicate, .4 Health Plan Customer Service, .5 Global Ratings.	CAHPS reports		Full	This requirement is addressed in the 2018_Anthem Adult- Healthy Blue (LA)_AM_CAHPS Report and Crosstabs and in the 2018_Anthem - Healthy Blue (LA)_CMCCC_CAHPS Report and Crosstabs.	
14.2.10.9	The MCO's vendor shall perform a LDH-approved behavioral health survey to be standardized across the MCOs. The survey results shall be reported to	P/P Behavioral health survey		Full	This requirement is addressed in the Healthy Blue BH LA- Adult 2018 Results, the Healthy Blue BH LA- Child 2018 Results, and in the	

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	LDH on an annual basis.	Timeline for BH survey administration BH survey results, if administered			BH-Medicaid19_SOW 041219 Statement of Work.	
14.4	**Health Plan Accreditation**					
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate.	
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate.	
14.4.3	The MCO shall provide LDH with a copy of its most recent accreditation review including:	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate.	
14.4.3.1	Accreditation status, survey type, and level (as applicable);	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate.	
14.4.3.2	Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate; however, this is a summary report and does not include recommended actions or improvements, or a corrective action plan.	
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the LA_Accreditation Summary Report and in the LA1802 Final Certificate.	
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days	Accreditation Status including copy of		Not applicable	Not applicable	

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Contract Reference	Contract Requirement Language (Federal Regulation: 438.240)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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.	accreditation report if accredited				
14.5	**Member Advisory Council**					
14.5.1	The MCO shall establish a Member Advisory 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.	Member Advisory Council Plan Member Advisory Council Composition Member Advisory Council Description including roles and responsibilities		Full	This requirement is addressed in the 2018 Healthy Blue HEAC Plan and in the 2018 QM Program Description Appendices A to F on pages 7 and 8.	
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council		Full	This requirement is addressed in the 2018 Healthy Blue HEAC Plan and in the 2018 QM Program Description Appendices A to F on pages 7 and 8.	
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.	Member Advisory Council Plan Member Advisory Council Composition		Full	This requirement is addressed in 2018 QM Program Description Appendices A to F on pages 7 and 8.	
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.	Member Advisory Council Plan		Full	This requirement is addressed in the 2018 HEAC Training Presentation and in the 2018 Q4 HEAC Meeting Notes.	
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	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan		Full	This requirement is addressed in the 2018 Healthy Blue HEAC Plan, with implementation addressed in the 2018 Q4 HEAC Meeting Notes, and submission to LDH addressed in the HBL 136 2018 A document.	

Quality Management						
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	shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.					
14.5.6.	LDH 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.	Member Advisory Council Plan		Full	This requirement is addressed in the HB Website Spanish posting, the 2018 Q3 Meeting Notes Spanish, the HEAC Dates Web Posting, the HEAC Minutes website, and the HEAC Meeting Notification, with supporting documentation in the 11/15/18 email RE: HBL-LA HEAC Meeting Notes Web Posting 11.14.18.	
14.6 14.6.1	**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 Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) 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.	Fidelity monitoring plan MOUs Evidence of submission to LDH		Full	This requirement is addressed in the Healthy Blue Fidelity Monitoring Plan 2019, with supporting documentation in the Homebuilders_Amerigroup MOU.doc (with automatic renewal since 2016 effective date). On-site, the MCO described how the IET PIP will monitor interventions to train providers and UM staff on ASAM, as well as a Report for Authorization consistent with ASAM criteria that is pending LDH approval.	
14.6.2	The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH specified ACT Monitoring tool. The MCO shall ensure their staff are properly trained on utilization of the identified ACT	Fidelity monitoring plan Evidence of submission to LDH		Full	This requirement is addressed in the Case Western Reserve University_HBL Executed document on page 32, with implementation addressed in Fidelity Monitoring Overview 9/26/18 and Cross-Training TRR & MRR 3/22/19.	

Quality Management						
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	Monitoring tool.					
14.6.3	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 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 LDH. Reports will be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.	Fidelity monitoring plan Site visit reports Evidence of submission to LDH		Full	This requirement is addressed in the Healthy Blue Fidelity Monitoring Plan 2019, and document submission is addressed in the 355 HBLSA2 Resubmit Report.	
14.8 14.8.1	**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 LDH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.	P/P BH reporting Critical incident reporting system		Full	This requirement is addressed in the Behavioral Health Adverse Incidents Monitoring and Reporting-LA Policy and Procedure and in the 326_Healthy Louisiana Adverse Incident Reporting Form_101618.	
14.8.2	The MCO, as directed by LDH, 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.					
14.8.3	The MCO shall submit reports to LDH concerning	P/P BH reporting		Full	This requirement is addressed in the monthly	

Quality Management						
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	quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.				Bayou Health Adverse Incident reports submitted to LDH, including the 326 HBL Excel files and pdf submission files provided in the 326 HBL Monthly zip folder.	
14.9	**Provider Monitoring Plan and Reporting**					
14.9.1	The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:	P/P BH reporting Evidence of report submission to LDH		Full	This requirement is addressed in the Behavioral Health Provider Monitoring-LA Policy and Procedure and the 356 February 2019 Submission- Provider Monitoring Healthy Blue.	
14.9.1.1	Review criteria for each applicable provider type/level of care;			Full	This requirement is addressed in the Healthy Blue Fidelity Monitoring Plan 2019.	
14.9.1.2	Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 4.	
14.9.1.3	Member interview criteria;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 4.	
14.9.1.4	Random audit selection criteria;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on pages 4-5.	
14.9.1.5	Tools to be used;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider	

Quality Management						
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					Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 5.	
14.9.1.6	Frequency of review, including schedule of reviews by provider type;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 5.	
14.9.1.7	Corrective actions to be imposed based on the degree of provider non-compliance with review criteria elements on both an individual and systemic basis;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 6.	
14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 6.	
14.9.1.9	Inter-rater reliability testing methods.			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 6.	
14.9.2	At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient /residential.	P/P BH reporting		Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 5.	

Quality Management						
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	Additional levels of care may be added at the discretion of LDH.					
14.9.3	The MCO's review criteria shall address the following areas at a minimum:					
14.9.3.1	Adherence to clinical practice guidelines;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 1.	
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 2.	
14.9.3.3	Cultural competency;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 2.	
14.9.3.4	Patient safety;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 2.	
14.9.3.5	Compliance with adverse incident reporting requirements;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 2.	
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider	

Quality Management						
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					Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 2.	
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective; individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 3.	
14.9.3.8	Continuity and coordination of care, including adequate discharge planning			Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 3.	
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized					

Quality Management						
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	behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.					
14.9.5	The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.	Provider Monitoring P/P		Full	This requirement is addressed in the Healthy Blue Healthy Louisiana Reporting-Provider Quality Monitoring Plan, in the document named 356 February 2019 Submission-Provider Monitoring Health Blue Final 2.27.2019.pdf, on page 6.	
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings, corrective actions, and improvements for Specialized Behavioral Health Services.	Provider Monitoring P/P Provider Monitoring Reports		Full	This requirement is addressed in the 358 HBL 2019 Q1 Resubmit Report and in the 358 HBL 2018 Q4 Resubmit 2 Report.	
14.10	**Outcome Assessment for Specialized Behavioral Health Services**					
14.10.1	The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.	BH outcome assessment plan Assessment Reports		Full	This requirement is addressed in the Continuity & Coordination of Care BH 2019 Policy and Procedure and the Healthy Blue Fidelity Monitoring Plan 2019, with implementation addressed in the 313 HBL 2019 Q1 Report and corresponding Submission document for specialized behavioral health.	
14.10.2	The MCO shall ensure providers and appropriate MCO staff are adequately trained/ certified in the use of such tools and such training/certification is current.	BH outcome assessment plan Training materials Evidence of Training Attendance		Full	This requirement is addressed in the 333 Strategy Report-Healthy Blue, and implementation is addressed in Report 349 HBL 2018 on page 2.	
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.	BH outcome assessment plan		Full	This requirement is addressed in the 333 Strategy Report-Healthy Blue 2019 and in the Healthy Blue Fidelity Monitoring Plan 2019,	

Quality Management						
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					with implementation addressed in the Report 349 HBL 2018 and the 333 Strategy Report LDH upload.	

Fraud, Abuse, and Waste Prevention

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act..					
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with LDH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at LDH'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.	FWA Compliance Plan		Full	This requirement is addressed in the March 2019 SIU Antifraud Plan. A sample Quarterly Meeting Invitation for Program Integrity SIU was provided to show the MCO is in compliance with the requirement.	
15.1.3	The MCO and its subcontractors 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, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, 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 ten (10) years from the expiration date of the Contract (including any extensions to the Contract), or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and	FWA Compliance Plan		Substantial	This requirement is partially addressed within the March 2019 SIU Antifraud Plan. Missing from the language is the requirement addressing that regulatory agencies may have access to information regarding the quality, timeliness and appropriateness of services 10 years from the expiration of the Contract or from the date of any audit completion, whichever is later. Also missing from the language is that under special circumstances, MFCU will be allowed after-hours admission. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
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	timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.				contract language and is in review with LDH. This can be presented at the next audit review.	
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, LDH, 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 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.	FWA Compliance Plan		Full	This requirement is addressed by the Federal State Agency Request for Access or Information document and is partially addressed on page 30 of the March 2019 SIU Antifraud Plan.	
15.1.5	The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained.					
15.1.6	The MCO and its providers and subcontractors 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.	FWA Compliance Plan		Substantial	This requirement is partially addressed by the March 2019 SIU Antifraud Plan on page 28. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
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					review.	
15.1.7	MCO's employees consultants, and its subcontractors 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.	FWA Compliance Plan		Full	This requirement is addressed in the March 2019 SIU Antifraud Plan on page 26.	
15.1.8	The MCO and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	FWA Compliance Plan		Substantial	This requirement language is missing in the March 2019 SIU Antifraud Plan on page 26. However, LDH approval of any grievance procedures prior to implementation is discussed in the Member Complaints and Grievances document. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language.	Requirement will be added to the Anti-Fraud Plan.
15.1.9	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 LDH policy.	FWA Compliance Plan		Substantial	The language is missing from the March 2019 SIU Antifraud plan. On pages 7 and 8 of the Program Integrity plan, cost avoidance integration with claims adjudication and cost containment activities are discussed. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.10	The MCO will report to LDH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms		Minimal	This requirement is not addressed in the March 2019 SIU Antifraud Plan. As discussed onsite, the MCO does ongoing monitoring of their provider network, employees and subcontractors. The MCO provided an Excluded Individuals and Entities policy.	Language will be added to Anti-Fraud Plan.

Fraud, Abuse, and Waste Prevention						
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	LDH Program Integrity contact.				However, language concerning sending reports to LDH within a three day timeframe is missing in the provided documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language.	
15.1.11	The MCO and its subcontractors shall have surveillance and utilization control programs and procedures pursuant to (42 CFR §438.608(a)(1)) 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 Compliance Plan		Full	The requirement is addressed in the March 2019 SIU Antifraud Plan. Onsite discussions with SIU and reporting staff show compliance with the requirement as the MCO has oversight of fraudulent activity.	
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) 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.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms		Minimal	The requirement is evidenced by the Provider Disclosure Form but the language is missing in the March 2019 SIU Antifraud Plan. As discussed onsite, disclosures are a part of the ongoing activities and credentialing processes overseen by the provider network. Disclosures are referenced in the provider agreement in section 6.23, but timeliness of routinely submitted disclosures is not addressed in any documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language. **Final Review Determination** No change in determination. Although the	Medicaid Subcontractors Disclosure of Ownership P&P – Full Document Credentialing Policies are to be revised to reflect all applicable timeframes.

Fraud, Abuse, and Waste Prevention						
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					documentation does satisfy the requirement and would be substantial evidence the MCO has policies in place that address this requirement, the Medicaid Subcontractors Disclosure of Ownership document was not provided for the pre-onsite review or the onsite follow-up documentation. Please provide this document to show compliance with the requirement for the next audit review period and please include language on the timeframes where applicable.	
15.1.13	The MCO, as well as its subcontractors and providers, 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.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms Employee Disclosure Forms		Full	This requirement is addressed on page 14 of the March 2019 SIU Antifraud Plan.	
15.1.14	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 50,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state. LDH may approve written requests with detailed	FWA Compliance Plan		Full	This requirement is addressed in the MCO's organizational chart (LA Compliance ORG Chart and 2019 SIU Org Chart). SIU Louisiana staffing meets the requirements of the contract language and skillsets vary amongst staff members that help contribute to the success of the team.	

Fraud, Abuse, and Waste Prevention						
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	justification to substitute another SIU position in place of an investigator position.					
15.1.15	LDH or its designee will notify the MCO when it 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:	FWA Compliance Plan		Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite. Language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. The MCO did confirm onsite that LDH approval is needed in order for recoupments or withholds to occur. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.15.1	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	FWA Compliance Plan		Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan		Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
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					prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.15.3	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.	FWA Compliance Plan		Minimal	This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.16	The prohibition described above in Section 15.1.15 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 LDH.	FWA Compliance Plan		Minimal	This requirement is not addressed by the Program Integrity Plan nor the March 2019 SIU Antifraud Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
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					contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.17	The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see 15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..	FWA Compliance Plan Payment Suspension P/P		Minimal	The language is missing from the March 2019 SIU Antifraud plan and is not addressed in the Program Integrity Plan. This requirement is minimally addressed by the Overpayments Policy. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18	**Reporting and Investigating Suspected Fraud and Abuse**					
15.1.18.1	The MCO and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.					
15.1.18.2	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.	FWA Compliance Plan		Full	This requirement is addressed in the SIU Antifraud Plan.	
15.1.18.3	The MCO shall notify MFCU and LDH 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	FWA Compliance Plan		Full	This requirement is referenced in the SIU Antifraud Plan. The MCO shows evidence of compliance with the 145 – FWA Activity Reports, the Fraud Referral Templates and Fraud Notice Template. Onsite, SIU staff discussed hotlines are available to employees and staff to report cases. All tips received are vetted, and if legitimate are pursued for investigation. Data mining, external data sources, fraudulent claims and appointment reviews are part of the investigative review process.	

Fraud, Abuse, and Waste Prevention						
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	LDH when the concerns and/or allegations of any tips are authenticated.					
15.1.18.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:	FWA Compliance Plan		Full	This requirement is addressed via reporting of tips and confirmed Fraud, Waste and Abuse to LDH, as discussed onsite with SIU staff. The MCO submits the 145 – FWA Activity report regularly to LDH.	
15.1.18.4.1	All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month) shall be reported to LDH Program Integrity monthly; LDH	FWA Compliance Plan Evidence of report submission		Full	This requirement is addressed via the 145 – FWA Activity Reports.	
15.1.18.4.2	Suspected fraud and abuse in the administration of the program shall be reported to LDH Program Integrity and MFCU;	FWA Compliance Plan		Full	This requirement is addressed via the 145 – FWA Activity Reports.	
15.1.18.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH Program Integrity and MFCU; and	FWA Compliance Plan		Full	This requirement is addressed by the Program Integrity Plan and discussed with SIU staff onsite. The MCO also provided a Fraud Referral Template and a Fraud Notice Template.	
15.1.18.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence..	FWA Compliance Plan		Substantial	The language of the contract is not addressed in the March 2019 SIU Antifraud Plan but staff was able to speak to the investigative process onsite. Provider and Member Fraud Referral Forms were provided. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.5	When making a referral of suspected fraud, the MCO shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of this	FWA Compliance Plan Provider referral forms		Substantial	The language of the contract is not addressed in the March 2019 SIU Antifraud Plan. MCO provided a Fraud Referral	Language has been added to the Anti-Fraud Plan and is currently in review with

Fraud, Abuse, and Waste Prevention						
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	Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form				Template and a Fraud Notice Template that shows compliance with the requirement. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	LDH.
15.1.18.6	The MCO shall be subject to a civil penalty, to be imposed by the LDH, for willful failure to report fraud and abuse by employees, subcontractors, beneficiaries, recipients, enrollees, applicants, or providers to LDH MFCU, as appropriate.					
15.1.18.7	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:	FWA Compliance Plan		Substantial	The language of the contract is partially addressed in the SIU Antifraud Plan and is partially addressed by the Investigations of Suspected Fraud and Abuse policy document. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan		Minimal	This requirement language, although referenced, is missing in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
					review.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan		Substantial	This requirement language is partially addressed on page 25 in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	FWA Compliance Plan		Minimal	This requirement language is not listed in the SIU Antifraud Plan, however, SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.1.18.8	The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	FWA Compliance Plan		Full	This requirement is addressed by the Investigations of Suspected Fraud and Abuse policy document and was discussed with SIU staff onsite. Reporting requirements meet LA requirements.	
15.1.18.9	The MCO and its subcontractors 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	FWA Compliance Plan		Substantial	The language is missing in the March 2019 SIU Antifraud Plan. MCO regularly meets with contracted vendors, and if vendors open a case, they notify the MCO so they can inform the state and a case is opened with the reporting vendor.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

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	administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.				Discussed onsite, the Dental vendor does their own investigations. The MCO has the ability to make referrals to vendors and has the ability to mine their vendor's data. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.1.18.10	The MCO and/or its subcontractors are 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.			Substantial	This requirement was discussed onsite. The MCO does not actively suspend payments to providers unless directed by the state. The Provider Garnishment Process does not meet compliance for this requirement as it pertains to Kentucky requirements. **Recommendation** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. **Final Review Determination** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana should be developed.	Overpayments Policy – Full Document Provider Hold Process – Full Document Payment suspension policy is being created specific to LA

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15.1.19	The State shall not transfer its law enforcement functions to the MCO.					
15.1.20	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.	FWA Compliance Plan Provider Agreement Form		Full	This requirement is met in Section 3.11 of the Provider Agreements.	
15.1.21	The MCO shall notify LDH when the MCO or its subcontractor 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.	FWA Compliance Plan Provider Enrollment, Disclosure & Credentialing Forms		Full	Provider Agreements, various credentialing policies on ongoing sanctions, terminations and revocation as well as a sample credentialing denial letter meet this requirement.	
15.1.22	The MCO shall report overpayments made by LDH to the MCO within 60 calendar days from the date the overpayment was identified.	FWA Compliance Plan		Full	This is addressed in the Overpayment policy and was discussed onsite with staff.	
15.1.23	Unless prior written approval is obtained from LDH, the MCO shall not employ extrapolation methods to derive an overpayment in a provider audit..	FWA Compliance Plan		Full	A sample overpayment notification letter is provided to show compliance, and recoupments require approval from LDH.	
15.2	**Fraud and Abuse Compliance Program**					
15.2.1	In accordance with 42 CFR §438.608(a), the MCO and its subcontractors, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the MCO and the state, 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.	FWA Compliance Plan		Full	A compliance organization chart, the 2019 Program Integrity document and the SIU antifraud plan meet this requirement.	
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the	FWA Compliance Plan		Full	Sarah Lorance was mentioned as the chief	

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	MCO's compliance program shall designate a contract compliance officer who is responsible for developing and implementing written policies, procedures, and standards to ensure compliance with the requirements of this contract and all applicable Federal and State requirements, and who reports directly to the CEO and board of directors. .				compliance officer.	
15.2.3	The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer	FWA Compliance Plan PI Org chart and resumes		Full	The SIU and PI staff confirmed and discussed the structure of the Program Integrity department.	
15.2.4	The MCO shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under the contract.	FWA Compliance Plan		Full	The SIU and PI staff confirmed and discussed the structure, activities, monitoring and reporting activities of the SIU and Program Integrity department.	
15.2.6	In accordance with 42 CFR 438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.	FWA Compliance Plan Compliance Committee Charter Compliance Committee meeting minutes		Full	The SIU and PI staff confirmed and discussed the organization structure, activities, monitoring and reporting activities of the SIU and Program Integrity department. An organization chart was also provided.	
15.2.6	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 LDH for approval at least thirty (30) days in advance of making them	FWA Compliance Plan		Full	Staff onsite discussed that the SIU Antifraud Plan that was in use during the audit required additional updates upon review by LDH, and an updated document was submitted after the review period to meet	

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	effective. LDH, 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:				LDH's requested changes to include all new contract language.	
15.2.6.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.2	Effective lines of communication between the Contract Compliance Officer and the MCO's employees, providers and contractors			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.3	Enforcement through well-publicized disciplinary guidelines;			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.4	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;			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.5	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;			Full	This requirement is addressed in the SIU Antifraud Plan. Annual companywide training on whistleblowing and training materials on ethics and compliance was discussed onsite.	
15.2.6.6	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);			Full	The 145 Report meets compliance for this standard.	
15.2.6.7	Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or			Full	This requirement is addressed by the non-retaliation policy. Whistleblower protections	

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	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 LDH and/or the U.S. Office of Inspector General.				were discussed with SIU staff onsite. This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.9	Procedures for prompt notification to LDH when the MCO receives information about changes in a member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.			Full	This requirement is addressed by the Member Disenrollment document.	
15.2.6.10	Procedures for prompt notification to LDH when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.			Full	This requirement is addressed in the SIU Antifraud Plan and Timely notification of Provider Participation document.	
15.2.6.11	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);			Full	This requirement is addressed in the SIU Antifraud Plan.	
15.2.6.12	Effective training and education system for the Contract Compliance Officer, program integrity investigators, managers, and members to ensure that they know and understand the federal and state standards and requirements of MCO's contract;			Full	This requirement is addressed in the SIU Antifraud Plan. New hire training and on-going training was discussed onsite with staff.	
15.2.6.13	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.			Full	This requirement is addressed in the SIU Antifraud Plan. New hire training and on-going training was discussed onsite with staff.	
15.2.6.14	The MCO will require new employees to complete			Full	This requirement is addressed in the SIU	

Fraud, Abuse, and Waste Prevention						
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	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 identification and reporting procedures • Federal False Claims Act and employee whistleblower protections • Procedures for timely consistent exchange of information and collaboration with LDH; • Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by 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.				Anti fraud Plan. New hire training and on-going training was discussed onsite with staff. I am Anthem Training Scripts, the New Hire EPIC document, and All Staff Mandatory Annual Compliance Training 2019 document was provided to show compliance.	
15.2.7	The MCO shall require and have procedures for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	Overpayments Policy Overpayments notice form		Full	An overpayment policy was provided to show compliance with this requirement, and staff addressed the identification and recoupment of overpayments process onsite. An email notification to LDH of Overpayment Letters was also provided.	
	The MCO shall have procedures for prompt	Overpayments Policy		Full	An overpayment policy was provided to	

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	reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.				show compliance with this requirement, and staff addressed the identification and recoupment of overpayments process onsite.	
15.3	**Prohibited Affiliations**					
15.3.1	In accordance with 42 CFR 438.610, the MCO and its subcontractors are prohibited from knowingly having a relationship with: An individual or entity that 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.					
15.3.4	The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR 438. 608 and 438.610 pertaining to debarment and/or suspension including written disclosure to LDH of any prohibited affiliation.. The MCO and its subcontractors shall screen all employees and contractors and network providers 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.	FWA Compliance Plan		Full	Each month, a notice is sent out to see that there is no conflict of interest; there is a department in the MCO dedicated to this process, and individuals complete a survey. Monthly checks are conducted to see that no member, provider, and subcontractor appear on the exclusion list. A Report 148 attestation shows compliance with this requirement.	
15.3.5	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 LDH	FWA Compliance Plan		Full	The MCO conducts these searches, especially for credentialing. A policy was provided named Excluded Individuals and Entities document.	
15.3.6	The MCO and its subcontractors shall conduct a	FWA Compliance Plan		Full	A policy document on Excluded Individuals	

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Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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 LDH 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 is a prohibited affiliation. 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).				and Entities was provided. Monthly ongoing process, as discussed onsite, check to see providers have no blemishes, egregious errors or probationary status; the credentialing committee will make determinations on if provider should stay within the network. LDH will be notified of any providers who are flagged. Provider relations team will help address if providers have moved, SIU team will investigate the issue, if there are issues with change of ownership. Any notification to LDH is done within a three day timeframe. LDH may give documentation to help reinstate the provider according to the documentation that LDH provides. If no reinstatement date, will retro date them to their termination, and providers may need to go back to the credentialing process to keep in line with the NCQA guidelines.	
15.3.6.1	An individual who is an affiliate of a prohibited person or entity described above include: • A director, officer, or partner of the MCO; • A subcontractor 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 under this contract. • A network provider.	FWA Compliance Plan		Full	Provider Contracts, Policy on Conflicts of Interest, and the Excluded Individuals and Entities policy document was provided to show compliance with this requirement.	

Fraud, Abuse, and Waste Prevention						
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15.3.6.2	The MCO shall notify LDH in writing 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.	FWA Compliance Plan		Full	Provider Contracts, Policy on Conflicts of Interest, and the Excluded Individuals and Entities policy document was provided to show compliance with this requirement.	
15.3.7	The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites referenced in 15.3.5 been completed to capture all exclusions.	FWA Compliance Plan Copies of monthly reports		Full	The 148 exclusion screening document satisfies this.	
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 certain emergency services ; and	FWA Compliance Plan		Full	This requirement is addressed by the Excluded Individuals and Entities policy.	
15.4.2	The MCO is responsible for the return to the State of any money paid for services provided by an excluded provider.	FWA Compliance Plan		Full	Recoupment processes were discussed onsite and a provider hold process workflow document was provided post-onsite.	
15.5	**Reporting**					
15.5.1	The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	FWA Compliance Plan		Minimal	This requirement was discussed onsite with staff, Although referenced on page A3, this requirement language is missing in the SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.5.2	The MCO shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, subcontractor or subcontractor 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, network provider or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	FWA Compliance Plan		Full	The Timely Notification of Participating Provider Terminations, Excluded Individuals policy, and Provider Manual on prohibitive affiliations show compliance with this item.	
15.5.3	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:					
15.5.3.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (under 42 CFR 455.14);	FWA Compliance Plan		Full	This requirement is addressed on the 145 Report.	
15.5.3.2	Number of complaints reported to the Contract Compliance Officer; and	FWA Compliance Plan		Full	This requirement is addressed on the 145 Report.	
15.5.3.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide LDH, 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.	FWA Compliance Plan		Full	This requirement is addressed on the 145 Report.	
15.5.3	The MCO, through its compliance officer, shall attest to LDH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	FWA Compliance Plan Attestation Form		Full	This requirement is addressed on the 148 Report attestations.	

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15.5.4	The MCO shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)] .	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed on the 145 Report.	
15.5.5	The MCO shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed on the 145 Report.	
15.5.6	LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 CFR §438.608(d)(4).					
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 as billed. 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:	P/P for medical records P/P for medical record documentation standards P/P for medical record monitoring Provider Manual Model Provider Contracts for all provider types		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.1.1	Accurate and legible;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
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	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2	The MCO shall ensure the medical record includes,	P/P for medical records		Full	This requirement is addressed by the	

Fraud, Abuse, and Waste Prevention						
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	minimally, the following:	P/P for medical record standards			Medical Record Review Policy.	
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
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;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.7	Signed and dated consent forms (as applicable);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.8	Documentation of immunization status;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.2.9	Documentation of advance directives, as appropriate;	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
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);	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	

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	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.					
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.	P/P for medical records P/P for medical record standards		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	P/P for medical records		Full	This requirement is addressed by the Medical Record Review Policy.	
15.6.4	All documentation and/or records maintained by the MCO its subcontractors, and all of its network providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ten (10) 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.	P/P for medical records P/P for medical record retention		Full	This requirement is addressed by the Medical Record Review Policy.	
15.7	**Rights of Review and Recovery by MCO and LDH**					
15.7.1	The MCO and its subcontractors is responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract,.	FWA Compliance Plan		Full	This requirement is discussed in the Investigations of Suspected Fraud and Abuse document.	
15.7.2	The MCO and its subcontractors shall have the right to audit and investigate providers and	FWA Compliance Plan		Substantial	This requirement is partially discussed in the Investigations of Suspected Fraud and Abuse	Language has been added to the Anti-Fraud Plan and

Fraud, Abuse, and Waste Prevention						
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	members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. The MCO shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status. 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 LDH.				document and overpayments are reported on the 145 Report. No documentation discussed the right to audit providers and members within a 5 year period. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	is currently in review with LDH.
15.7.3	All reviews shall be completed within eight months (240 calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.	FWA Compliance Plan		Substantial	The language is missing in the SIU Antifraud Plan. This requirement was discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.4	The MCO shall confer with LDH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by LDH.	FWA Compliance Plan		Substantial	This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. Post-payment is discussed in the Program Integrity Plan. This requirement was discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

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15.7.5	Contact with the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH	FWA Compliance Plan		Minimal	This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. This requirement was addressed onsite by the MCO, but the language was not found in submitted documentation. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.6	If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of the Department approved proceeding with the recoupment (per 15.1.17), unless an extension or exception is authorized by the Department, or the MCO has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, the Department or its agent may recover the overpayment from the MCO and said funds will be retained by the State. Exception reasons may include, but are not limited to, MCO cooperation with LDH or other government agencies, termination of provider participation with the MCO, or dissolution of the provider's business.					
15.7.7	LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. LDH may recover from the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.	FWA Compliance Plan		Minimal	This requirement language is partially addressed in the Overpayments Policy and is missing in the SIU Antifraud Plan although the requirement is referenced on page A3. Missing from all documentation was the requirement of the right to audit within a 5 year period from the date of service of a claim.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

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					Recommendation The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.7.8	LDH shall not initiate its own review on the same claims for a network provider which has been identified by the MCO as under a review approved by LDH per Section 15.7.4. LDH shall track open LDH and MCO reviews to ensure audit coordination. LDH shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.					
15.7.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a response from the MCO within ten business days, the State may proceed with its review.	FWA Compliance Plan		Substantial	The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. An MCO Fraud Referral Template was provided to show evidence of compliance. Onsite, SIU unite confirmed they have a case tracking system. **Recommendation** The MCO should update the SIU Antifraud plan, which is in review with LDH, to include this requirement language.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
15.7.10	In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless	FWA Compliance Plan		Minimal	The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. The 14 day timeliness of compliance with state requests is not written in any documentation.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.

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	another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.				**Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	
15.7.11	LDH shall notify the MCO and the network provider concurrently of overpayments identified by the State or its agents.					
15.7.12	The MCO shall not correct claims not initiate an audit on the claims upon notification of identified overpayment by the Department or its agent unless directed to do so by the Department.	FWA Compliance Plan		Full	This requirement is discussed in the Overpayment Policy.	
15.7.13	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 will notify the MCO and the MCO shall initiate a payment withhold on the provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected . Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.	FWA Compliance Plan		Full	This requirement is discussed in the Overpayment Policy.	
15.7.14	In the event LDH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH.					

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15.7.15	The MCO and its subcontractors shall enforce LDH directives regarding sanctions on MCO network providers and members, up to termination or exclusion from the network.	FWA Compliance Plan		Full	This requirement is addressed in the Excluded Individuals and Entities policy document.	
15.7.11	There will be no LDH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Medicaid Managed Care Contract period of for providers for which no MCO relationship existed.	FWA Compliance Plan		Minimal	The requirement language is missing in the March 2019 SIU Antifraud Plan. Recoupments were discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Language has been added to the Anti-Fraud Plan and is currently in review with LDH.
	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.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the Excluded Individuals and Entities policy document.	
4.1.4	The MCO shall comply with LDH Policy 8133-98,	FWA Compliance Plan		Full	This requirement is addressed by the	

Fraud, Abuse, and Waste Prevention						
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	"Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide LDH 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.				Excluded Individuals and Entities policy document and the 148 report on exclusion screening 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. LDH 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].	FWA Compliance Plan		Full	A key staff grid was provided in the pre-onsite documentation and that is submitted to the state.	
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.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed by the Excluded Individuals and Entities policy document and the 148 report on exclusion screening attestation.	
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	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed by the Excluded Individuals and Entities policy document and the 148 report on exclusion screening attestation.	

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	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.					
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 LDH or its authorized agent(s).	FWA Compliance Plan		Substantial	This requirement is not addressed by the Provider Garnishment Desktop Procedure as the provided document pertains to Kentucky requirements, not Louisiana. **<u>Recommendation</u>** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. **<u>Final Review Determination</u>** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana should be developed.	Overpayments Policy – Full Document Provider Hold Process – Full Document Payment suspension policy is being created specific to LA
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	FWA Compliance Plan		Full	This requirement is addressed by the Excluded Individuals and Entities policy document and the 148 report on exclusion screening attestation.	

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	submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4					
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 LDH 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.	FWA Compliance Plan		Full	This reported to the state in the 170 HBL Disclosures of Ownership.	
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to LDH 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 LDH, 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,	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This reported to the state in the 170 HBL Disclosures of Ownership. This report was discussed onsite.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	"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 –** 18.3.1 The MCO shall report to LDH 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. 18.3.2 Federally qualified MCOs are exempt from this requirement. LDH 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.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This reported to the state in the 170 HBL Disclosures of Ownership. This report was discussed onsite. The MCO provided as a statement that "As a wholly owned subsidiary of Anthem, Healthy Blue has no individual owners and therefore, there are no such transactions with a "party in interest" to report."	
18.7	The MCO shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	The MCO provided a Provider Person Disclosure Form to show evidence of compliance.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.					
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 non-procurement 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.LDH.la.gov/; and/or • the System for Award Management, http://www.sam.gov .	FWA Compliance Plan		Full	The MCO addresses this requirement in the Excluded Individuals and Entities document and the 148 HBL report attestation on exclusion screenings. Screenings also occur during the credentialing process to verify providers are not on exclusionary lists.	
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 LDH. 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	FWA Compliance Plan		Full	The requirement is partially addressed by the Monthly Exclusion Screening Attestation and the excluded individuals policy document. Exclusions and criteria for not participating with excluded providers was discussed onsite.	

Fraud, Abuse, and Waste Prevention						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	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; 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.	FWA Compliance Plan				

Reporting

Reporting						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.242)	Suggested Documentation and reviewer instructions	Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	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, claims, 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.	Screen shot of health informatics system System reports		Full -	This is addressed in the Process and Responsibilities for the Development Review and Submission of Regulatory Reports Policy. Healthy Blue provided a spreadsheet containing all reports that are submitted to LDH. Developed internal plan regarding if LDH has questions for reporting. Tracked and then put on internal LOC if often. Healthy Blue uses LDH SharePoint for submissions to LDH. LDH usually responds within 15 business days.	