United Healthcare

2019 Compliance Audit

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

Final Report Issued December 2019

Prepared on Behalf of
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Louisiana Department of Health

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Table of Contents

List of Tables

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 United Healthcare (UHC).

Audit Overview

The purpose of the audit was to assess UHC'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 UHC'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 UHC 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 UHC on July 10 and 11, 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 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	103	7	1	0	4	93%
Provider Network Requirements	184	167	15	0	0	0	91%
Utilization Management	87	85	2	0	0	0	98%
Eligibility, Enrollment, and Disenrollment	13	11	2	0	0	0	85%
Marketing and Member Education	83	80	3	0	0	0	96%
Member Grievance and Appeals	65	65	0	0	0	0	100%
Quality Management	114	113	0	0	0	1	100%
Fraud, Abuse, and Waste Prevention	118	116	1	1	0	0	98%
Reporting	1	1	0	0	0	0	100%
TOTAL	**780**	**741**	**30**	**2**	**0**	**5**	**96%**

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

As presented in **Table 3**, 780 elements were reviewed for compliance. Of the 780, 741 were determined to fully meet the regulations, while 30 substantially met the regulations, 2 minimally met the regulations and none were determined to be non-compliant. Five elements were "not applicable." The overall compliance score for UHC was 96% 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 UHC submit a corrective action plan for each of the 32 elements determined to be less than fully compliant in **Table 4**, along with a timeframe for completion of the corrective action. Note that UHC 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. One-half of the issues noted related to UHC's provider network adequacy and their ability to contract with providers in several specialty and sub-specialty areas–a problem prevalent in the Louisiana Medicaid Managed Care program as well as PCPs in urban areas of the state.

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					
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Member handbook P/P ER services	Substantial	This requirement is addressed in the UCSMM Policy 04 11 Consumer Safety Policy and in the Management of Behavioral Health Benefits Medicaid National (0219 Final) Policy and Procedure on page 3. The Member Handbook for Integrated Health Services indicates, on pages 21 and 22, that the member does not need a prior authorization for emergencies, with specific reference to mental health and substance use on page 42; however, the handbook also includes a brief paragraph on page 50 regarding crisis intervention as a service with an authorization requirement. **<u>Recommendation</u>** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the MCO agreed to do so. **<u>Final Review Determination</u>** No change in determination. The plan addressed the recommendation after the review period.	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case	P/P Individual Treatment Plans CM records Treatment &/or care plans	Substantial	This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure. **<u>File Review Results</u>**	1. The Plan will educate our staff on EQRO audit recommendations. 2. The case management team will take the approach

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	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:	Includes Case Management File Review		Of the 10 case management files, 9 had an individual care plan based on the needs assessment, and 9 of 10 care plans included short- and long-term care goals. Of the 8 applicable files (excluding 2 with multiple unsuccessful outreach attempts), 8 plans of care were developed with member and/or family involvement. Of the 10 behavioral health case management files, the requirement for a care plan was applicable to 9 cases (excluding 1 PASRR case). Of the 9 applicable cases, 8 had a care plan based upon the member's individual needs assessment that was developed with the involvement of the member/family, and that included short- and long-term member goals. Nine (9) of 9 applicable files (excluding 1 PASRR case) included a care plan that documented member demographics and supports and services. Of the 8 files with documented indication for crisis planning, 8 met this requirement. **Recommendation** The MCO should encourage clinical case managers to tailor the plan of care to the member's individual needs beyond those identified by the member in the initial needs assessment. **Final Review Determination** No change in determination. The plan agreed to the recommendation moving forward.	of being more specific in the care plan, including notations within the care plan under each O.G.I. (Opportunity, Goals, and Interventions) specific to the member's needs regardless of whether it applies to resources or disease specific processes. 3. The case management team will document updated findings within the member's plan of care. All notes will reflect information and updates through the period of member's enrollment.

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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 is addressed for Medicaid, CHIP, dual Special Needs Plans (DSNP), and Medicare/Medicaid Program (MMP) plans in the NCM 002 High-Risk Case Management Process Policy and Procedure. **File Review Results** The requirement for ongoing care plan review was applicable to 6 case management files (4 were excluded due to lack of sufficient timeframe for care plan follow-up or multiple unsuccessful outreach attempts. Six (6) of 6 files met the requirement for ongoing care plan review. Monitoring of outcomes and revision of the treatment plan as necessary was documented in either the care plan or care coordination notes for 7 of the 7 applicable cases (excluding 3 without sufficient timeframes). Of the 8 applicable behavioral health case management files7 documented monitoring of outcomes. Of the 7 applicable behavioral health case management files, 6 documented revision of the care plan as necessary. **Recommendation** The MCO should ensure that care plans are used to monitor and communicate member outcomes, with revisions made as indicated and communicated to behavioral health and physical health care managers and providers. The MCO should enhance case management interventions for the IET PIP.	The plan will educate our staff on the EQRO audit recommendations.

Deficient 2019 Audit Elements					
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				Final Review Determination No change in determination. The plan agreed to the recommendation moving forward.	
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	Substantial	This requirement is addressed in the NCM 006 Integration of Physical and BH Care Policy and Procedure, in the CS_WPC_Chronic Illness_Prgrm Management Procedure document, , in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description, and the Member Handbook for Integrated Health Services; however, it is not clear how this requirement is met for members with physical health or behavioral health benefits, only, per documentation in the Member Handbook for Physical Health Services and in the Member Handbook for Mental Health and Substance Use Treatment. **File Review Results** Of the 9 applicable case management files (excluding 1 with multiple unsuccessful contacts), 9 contained documentation that prevention and treatment services are accessible and comprehensive. Of the 8 applicable case management files (excluding an additional member without indications for referral), 8 met the requirement for referrals as indicated. Of the 8 applicable behavioral health case management files, 8 met the requirement for recording the member's PCP in the care management record or	

Deficient 2019 Audit Elements					
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				otherwise follow-up. **Recommendation** The MCO should revise the member handbooks for members with either one physical or behavioral health benefits only to explain to members that they are entitled to care coordination and how to access that care coordination. The MCO should improve behavioral case management to ensure that all members have access to comprehensive prevention and treatment services. **Final Review Determination** No change in determination. There was no MCO Response and Plan of Action..	
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 CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure, CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure, and CS_WPC_Intensive Opportunity_Prgrm Mgmt Policy and Procedure, as well as in the entitled 2018 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care on page 28. **File Review Results** Of the 10 case management files reviewed, 8 met the requirement for ongoing care coordination, although initial coordination of activities with the Chronic Care Management Program was documented for 10 of 10 files. Five (5) of 7 files with behavioral health conditions received behavioral health care	1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care.

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				coordination. Eight (8) of 8 applicable files met the requirement for referrals made when necessary. Of the 10 behavioral health case management files, 9 of the 9 applicable files met the requirement for ongoing care coordination, as well as the requirements for coordination of activities with the Chronic Care Management Program as applicable, and for referrals when necessary. Contact was made with the Integrated Medicaid Managed Care Program plan care manager for 10 of 10 files. **Recommendation** The MCO should improve overall care coordination by increasing the involvement of clinical (i.e., RN) care managers (CMs) in order to supplement nonclinical community outreach workers' successful contacts with active member engagement in CM, with communication to local MCO staff in a comprehensive care coordination policy and procedure that is applicable to all members. In addition, the MCO should encourage greater involvement of clinical CMs to tailor the POC to members' individual needs beyond those identified by the member and programmed by the CM software based upon the initial health assessment. The MCO should encourage enhanced clinical CM interaction with to improve POC monitoring and revision by enhancing continuity of clinical care across multiple CM episodes.	

Deficient 2019 Audit Elements					
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				Final Review Determination No change in determination. The plan agreed to the recommendation moving forward.	
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	Substantial	This requirement is addressed in the UHC_CS_WPC_Program Description, and in the member handbook on pages 13 and 14. **File Review Results** Of the 10 case management files reviewed, this requirement was applicable to 9 (excluding 1 file that documented multiple unsuccessful outreach attempts to contact the member). Of the 9 applicable files, 9 met this requirement. Of the 10 behavioral health case management files reviewed, this requirement was applicable to 8, with 7 of 8 files meeting the requirement for an ongoing source of preventive and primary care; however, release of information from the member/family was obtained to coordinate care with the PCP and other healthcare providers for 8 of 8 applicable files. **Recommendation** The MCO should improve BH follow-up case management to ensure ongoing access to and receipt of comprehensive preventive care. **Final Review Determination** No change in determination. The plan	1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care.

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				agreed to the recommendation moving forward.	
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 that:	P/P for care coordination Includes Care Management File Review	Substantial	This requirement is addressed in the Discharge Planning Policy, the RX-046 Automated Transition of Care Policy and Procedure, in the CS_WPC_Transitions of Care Policy and Procedure, and in the Coordination of BH Care Policy and Procedure. **File Review Results** Of the 10 case management files reviewed, 10 met this requirement. Of the 10 behavioral case management files reviewed, there were 8 applicable files (i.e., members with a hospitalization). Of these 8, 5 met the discharge planning requirement. **Recommendation** The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO should address this opportunity in the IET PIP, as well as more broadly for the behavioral health population. **Final Review Determination** No change in determination. The plan agreed to the recommendation moving forward, with several actions implemented during the current period, although after the review period.	1. The plan will educate our staff on the EQRO audit recommendations. 2. UM includes case management in their bi-weekly meeting. UM care advocates are prompted to include case management when involvement is beneficial for the member -- this has been in place since approximately May 2019. 3. Discharge planning from an interdisciplinary perspective is in place - including inpatient case management, utilization management, and case management. The UM team begins the discharge plan at the time of admission. After reviewing the facility's discharge plan, the UM team can make recommendations if they identify gaps/issues/concerns with the member. High needs members are being identified through a specific report and addressed in this interdisciplinary process. UM engages in discharge discussions at the beginning of the member's inpatient

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					stay. 4. Training for the case managers was completed July 8th. The training included: • CHW scope of practice o Individuals with a SUD need a referral to a BHA to address SUD component of gaps in care o Referrals and resources related to SUD or other BH needs are best addressed by BHA • Team opportunities field visits o CHWs, RNs, and BHAs can conduct a collaborative field visit in any member's home (especially members with BH needs or SUD) o Leverage technology when possible (Web-ex for virtual visit if BHA not in area/ Chris, Karen and Shelby will need Web-ex access) • Provider access o Live and Work Well for Virtual BH visits • MAT (medication assistance therapy) providers o Medical providers are able to provide MAT • Peer support education o Currently 1 internal PSS to support all of Louisiana

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					(time is split ½ PSS and ½ PSH) o Possible resources for external peer support specialist teams 5. Quality is working with the Community Healthcare Workers to support through education on how to provide members with information when SUD or BH issues are present.
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	Minimal	This requirement is addressed in the 6_4_10_Safe Haven LOI_Redacted Optum Letter of Intent to provide crisis stabilization services, dated January 29, 2019, but does not document availability of crisis intervention and stabilization services to members during the review period. The Member Handbook for Integrated Health Services includes a mental illness and addiction crisis line on page 3 and also includes a brief paragraph regarding crisis intervention as a service; however, there is an authorization requirement on page 50 documentation. **Recommendation** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the MCO agreed to do so.	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.

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				Final Review Determination No change in determination. The plan addressed the recommendation after the review period.	
Provider Network Requirements					
7.3.0	The MCO shall comply with the following maximum 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	Substantial	This requirement is partially addressed in the Network Provider Development Management on pages 4 to 8. **Recommendation** The MCO should incorporate the new contract language in the Network Provider Development Management Plan. Specifically, the MCO should replace "as determined by LDH approved mapping software" with "as specified in the Provider Network Companion Guide."	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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 addressed in the Network Provider Development Management on page 4. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The MCO's Q1 2019's Geo Access Report indicates that not all urban parishes	UHC Networks Division will continue its efforts to improve access to PCP's for members located in urban parishes. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.

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				meet the access standards for PCPs, but all rural parishes meet the access standards for both adult and pediatric PCPs. **Recommendation** The MCO should improve access to PCPs for their urban members.	
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 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Adequacy standards for distance are mostly met for rural parishes. Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for hospitals. **Recommendation** The MCO should improve access to hospitals for their urban members and improve access for members residing in the rural parish of Tensas.	Currently there are no hospitals located within Tensas Parish. All hospitals in neighboring parishes of Franklin, Madison, and Concordia are contracted with UCCCP. The nearest in-network hospital is located within 32 miles of Tensas parish.
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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial	This requirement is partially addressed in the Network Provider Development Management Plan on page 5. Currently, it states, "Travel distance to each specialty type shall not exceed 15 miles and 30 minutes." This is more restrictive than what is listed in the requirement; however, the Q1 2019 Report and a Q4 2018 Gap Analysis Report show evidence	UHC will update the Network Development Management Plan to include the specific requirements related to OB/GYN providers as defined in the in the LDH Network Companion guide.

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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 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.			that the MCO addresses the requirement language. Approximately 95% or better of members have access to each of the listed specialists within 60 miles of residence. All members are within 60 miles of an Ophthalmologist or Otorhinolaryngology specialist. **Recommendation** The MCO should update the language in the Network Development Plan regarding access to specialists.	
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Most of rural region members are within distance to a lab, but only 45% of members in Tensas Parish have access to a lab within the standards listed. Most of urban region members are within distance to a lab, but only 57% of members in Ouachita Parish have access to a lab within the standards listed.	UHC Networks Division will continue its efforts to improve access to labs for all members with a heightened focus on the parishes of Tensas and Ouachita. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.

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 improve access to lab services for all rural and urban members.	
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The access standards are met for rural regions. Most but not all urban regions meet the access standards for pharmacy services. **Recommendation** The MCO should improve access to pharmacy services for all urban members.	UHC Networks Division will continue its efforts to improve access to pharmacy services for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
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 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 as proof of compliance. The access standards are met for most rural regions. Some urban regions meet the access standard for pharmacy. **Recommendation** The MCO should improve access to pharmacy services for all rural and urban members.	UHC Networks Division will continue its efforts to improve access to hemodialysis centers for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
7.3.7	**Specialized Behavioral Health**	Network Provider	Substantial	This requirement is partially addressed in	UHC will update the

Deficient 2019 Audit Elements					
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7.3.7.1	**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.	Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least 90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH GeoAccess Report shows that 100% of members have access to BH specialists. **Recommendation** The MCO should update the access standard language on page 6 to address that access to BH specialists should not exceed the 30 miles or 60 minutes for 90% of rural members.	Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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 partially addressed in the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least 90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH Geo Access Report shows that 100% of members have access to BH specialists. **Recommendation** The MCO should update the access standard language on page 6 to address	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH 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
				that access to BH specialists should not exceed the 15 miles or 30 minutes for 90% of urban members.	
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	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of members have access to Psychiatric inpatient hospitals. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that access to psych hospitals should not exceed the 90 miles or 90 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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	Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and 99.8% of rural members have access to ASAM Level 3.3 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
7.3.7.5	Travel distance to ASAM Level	Network Provider	Substantial	This requirement is partially addressed in	UHC will update the

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
	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.	Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and 98.3% of rural members have access to ASAM Level 3.5 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members.	Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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 Requests for exceptions	Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and rural members have access to ASAM Level 3.7 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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	Network Provider Development and Management Plan P/P for Access and	Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability	UHC will update the Network Development Management Plan to include the specific time 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**
	for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Availability GeoAccess reports Requests for exceptions		Report. 100% of urban members and rural members have access to ASAM Level 3.7 WM providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members.	distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	Network Provider Development and Management Plan P/P for Access and Availability Evidence of meeting provider to member ratios	Substantial	This requirement is partially addressed in the Q1 2019 220 Report. Region 6 does not meet ratio standards for allergy, dermatology and endocrinology, specialists. Region 5 does not meet the ratio standard for dermatology, and Region 8 does not meet the standard ratio requirement for endocrinology. **Recommendation** The MCO should recruit enough specialists to meet the ratio standards for specialists across all regions of Louisiana.	UHC Networks Division will continue its efforts to increase the number of specialists within the regions that do not currently meet the standard ratio requirement. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
Utilization Management					
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%)	Provider contracts Compliance reports	Substantial	This requirement is partially addressed in the Clinical Practice Guidelines and the Provider Manual. UHC provided reports documenting the tracking of the rates. However, they were not achieving the 80% compliance rate. **Recommendation**	The health plan agrees with the recommendation. The health plan will promote the use of Clinical Practice Guidelines with incentives to improve compliance to 90% or higher.

Deficient 2019 Audit Elements					
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	or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.			The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	
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	P/P certification Tracking report P/P for UM Hospital reports	Substantial	This requirement is partially addressed in the Standard Operating Procedure Certification/Recertification of PRTF services. However, the new contract language is not included. **Recommendation** The MCO should incorporate the new contract language into the standard operating procedure.	The plan agrees and has updated its document to include the contractual language in this section.

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	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 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				

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	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.				
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	Policy for Member Disenrollment	Substantial	This requirement is addressed in the disenrollment policy. The first two bullets are not addressed in the member handbooks. Post-onsite, a member newsletter and integrated welcome letter included language on member rights, and makes reference to member services should members need	This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.

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	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 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.			assistance in addressing concerns. **Recommendation** The MCO should incorporate the language of the contract into the member handbook so that members are directly informed of their disenrollment rights.	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Policy for Member Disenrollment	Substantial	This requirement is addressed in the disenrollment policy. Members are encouraged to call the Enrollment Broker, whose number is listed in all three handbooks. However, there is no explicit reference to this as the Enrollment Broker's contact number.	This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.

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
				Members should be directly informed that is who they need to reach out to with disenrollment requests. **Recommendation** The MCO should update the written language in the handbook(s) to state that members (or their representative) must contact the Enrollment Broker, and the number listed in the book is in reference to the Broker.	
Marketing and Member Education					
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	Substantial	This requirement is partially addressed through the member handbook. The MCO provided a screenshot of a Member and Provider Call Centers via screen via their Benefit Matrix showing it is available through both in and out of network. However, an explanation should be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. **Recommendation** The MCO should include information in the member handbook explaining that the MCO cannot require the enrollee to obtain a referral before choosing family planning provider.	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	Policy for Provider Directory Provider Directory (website link)	Substantial	This requirement is partially addressed through the web URL that was submitted for the provider directory. A web-based machine-readable version is not available.	UHC has initiated Accessibility procedures for new documents (like Member Handbooks) or document updates. The Plan

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 make available a web-based machine-readable version.	will have all web-based machine readable content available by 12/31/19.
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;	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial	This requirement is addressed in the hard copy provider directory as well as the online version. However, website URLs and the provider's cultural competency training are not included. **Recommendation** The MCO should include both the website URL and the provider's cultural competency training in their directory.	The Plan agrees and will include both the website URL and the provider's cultural competency training in the directory.
Fraud, Abuse, and Waste Prevention					
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	FWA Compliance Plan	Substantial	This requirement is not addressed in the FWA plan but is addressed by the record keeping section of the Community and State Appeals policy. The MCO provided their Grievance and Appeals Reports (112 and 113 Reports).	This language was added to the FWA Compliance Plan and submitted to LDH in August 2019.

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	practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.			**Recommendation** The MCO should include this language in the FWA Compliance Plan.	
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 partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH.	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.

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 CS_LA_HousingLiaisionPrgrm_PSH Workflow.	

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		P/P member education				
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 CS_LA_HousingLiaisionPrgrm_PSH Workflow on page 4.	
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 CS_LA_HousingLiaisionPrgrm_PSH Workflow, on page 3.	
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 United Rosters_July 2018 thru March 2019 Report.	
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 LA Org Chart and Functional Responsibilities 2019, page 2, the CS LA Housing Liaison Program Policy and Procedure on page 3, and in the resume provided for the Optum peer support staff.	
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 Benefits_EQRO_2019_UHC_LA_LA_Behavioral_Health_Resources, theRevised_022819_PCA-1-011618-08012018_09062018_LA, and the Interim PIP entitled Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD (9/28/18) on page 26.	
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 factors, trauma, and adverse childhood	Provider handbook Provider education materials Provider contracts P/P provider education		Full	This requirement is addressed in the 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 36 and 55.	

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
	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 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on page 46, and in the Interim PIP entitled Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD (9/28/18).	
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		Minimal	This requirement is addressed in the 6_4_10_Safe Haven LOI_Redacted Optum Letter of Intent to provide crisis stabilization services, dated January 29, 2019, but does not document availability of crisis intervention and stabilization services to members during the review period. The Member Handbook for Integrated Health Services includes a mental illness and addiction crisis line on page 3 and also includes a brief paragraph regarding crisis intervention as a service; however, there is an authorization requirement on page 50 documentation. **Recommendation:** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.

Core Benefits and Services						
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					MCO agreed to do so. **Final Review Determination**: No change in determination. The plan addressed the recommendation after the review period.	
6.8	**Emergency Medical Services and Post Stabilization Services**					
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.	Member handbook P/P ER services		Substantial	This requirement is addressed in the UCSMM Policy 0411 Consumer Safety Policy and in the Management of Behavioral Health Benefits Medicaid National (0219 Final) Policy and Procedure on page 3. The Member Handbook for Integrated Health Services indicates, on pages 21 and 22, that the member does not need a prior authorization for emergencies, with specific reference to mental health and substance use on page 42; however, the handbook also includes a brief paragraph on page 50 regarding crisis intervention as a service with an authorization requirement. **Recommendations:** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the MCO agreed to do so. **Final Review Determination**: No change in determination. The plan addressed the recommendation after the review period.	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.
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	Member handbook		Full	This requirement is addressed in the Member Handbook for Integrated Health Services on page 22.	

Core Benefits and Services						
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	Glossary.					
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) document and the UCSMM Policy 04 11, Consumer Safety Policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) document on page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) document on page 4 and in the UCSMM Policy 04 11 Consumer Safety Policy.	
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.	P/P Coordination of services Communications to hospital		Full	This requirement is in the Management of Behavioral Health Benefits Medicaid National (0219 Final) document on page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy.	
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	P/P Coordination of Services Quality of core plan Member handbook		Full	This requirement is addressed in the Member Education Document ER Diversion Materials, and the LA ER Diversion_SR29 Progress Measures specifications address Pre-ED Visit Primary Care Provider Contact Rate. This requirement is addressed in the	

Core Benefits and Services						
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	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.				2019 Whole Person-Centered Care Management Program Description, and the 2019 Utilization Management Description.	
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 Member Education Document ER Diversion Materials and in the Optum Provider Express Psych Hub Video Library.	
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 Emergency Room Volume Report_Brown 6-23-18_6_18_19 Document and the LA UHC CP Medicaid Utilization Management Policy on page 5, and in the UCSMM Policy 04 11 Consumer Safety Policy.	
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member handbook		Full	This requirement is addressed in the Member Handbook for Integrated Health Services on page 21.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) documenton page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy.	

Core Benefits and Services						
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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 Management of Behavioral Health Benefits Medicaid National (0219 Final) on page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy..	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) document on page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) document on page 4, and in the UCSMM Policy 04 11 Consumer Safety Policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) on page 4, and in the UCSMM Policy 04 11 Consumer Safety policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) on page 4,	

Core Benefits and Services						
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					and in the UCSMM Policy 04 11 Consumer Safety policy.	
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 Management of Behavioral Health Benefits Medicaid National (0219 Final) on page 4, and in the UCSMM Policy 04 11 Consumer Safety policy..	
6.8.2.2.4	The member is discharged.	P./P post stabilization services		Full	This requirement is addressed in the Management of Behavioral Health Benefits Medicaid National (0219 Final) on page 4, and in the UCSMM Policy 04 11 Consumer Safety policy.	
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 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					

Core Benefits and Services						
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	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 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	HRA P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure and in the Special Healthcare Needs document. **File Review Results** Ten (10) of 10 case management files reviewed met the requirement for an individual needs and diagnostic assessment within 90 days of identification of need. Only one of these members had a documented	

Core Benefits and Services						
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	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.				referral source of special health care needs, and this member did have a care plan in progress. Ten (10) of 10 behavioral health case management files reviewed documented contact with the Integrated Medicaid Managed Care Program plan care manager. Regarding the requirement for an individual needs assessment, there were 9 applicable files (excluding 1 PASRR/OASS placement case). Nine (9) of 9 applicable files met the requirement for an individual needs and diagnostic assessment. Zero (0) of the 9 applicable files were documented as SHCN per the MCO's method of identification using the referral source. Zero (0) of the 9 applicable files were enrolled in CSoC.	
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 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.	P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review		Full	This requirement is addressed in the NCM012 Risk Stratification Process Policy and Procedure and in the Job Aid-JA99970908 CS-WPC-National-Team-VCHW-Clinician-Program-Mgmt 6.17.19 Policy and Procedure on page 3.	

Core Benefits and Services						
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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 CS_WPC_LA_Care Management Process Policy and Procedure. **File Review Results** Of the 10 case management files, 9 had an individual care plan based on the needs assessment, and 9 of 10 care plans included short- and long-term care goals. Of the 8 applicable files (excluding 2 with multiple unsuccessful outreach attempts), 8 plans of care were developed with member and/or family involvement. Of the 10 behavioral health case management files, the requirement for a care plan was applicable to 9 cases (excluding 1 PASRR case). Of the 9 applicable cases, 8 had a care plan based upon the member's individual needs assessment that was developed with the involvement of the member/family, and that included short- and long-term member goals. Nine (9) of 9 applicable files (excluding 1 PASRR case) included a care plan that documented member demographics and supports and services. Of the 8 files with documented indication for crisis planning, 8 met this requirement. **Recommendation** The MCO should encourage clinical case managers to tailor the plan of care to the member's individual needs beyond those identified by the member in the initial needs assessment.	1. The Plan will educate our staff on EQRO audit recommendations. 2. The case management team will take the approach of being more specific in the care plan, including notations within the care plan under each O.G.I. (Opportunity, Goals, and Interventions) specific to the member's needs regardless of whether it applies to resources or disease specific processes. 3. The case management team will document updated findings within the member's plan of care. All notes will reflect information and updates through the period of member's enrollment.

Core Benefits and Services						
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					Final Review Determination: No change in determination. The plan agreed to the recommendation moving forward.	
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 CS_WPC_LA_Care Management Process Policy and Procedure and in the NCM 002 High-Risk Case Management Process Policy and Procedure.	
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 is addressed for Medicaid, CHIP, dual Special Needs Plans (DSNP), and Medicare/Medicaid Program (MMP) plans in the NCM 002 High-Risk Case Management Process Policy and Procedure. **File Review Results** The requirement for ongoing care plan review was applicable to 6 case management files (4 were excluded due to lack of sufficient timeframe for care plan follow-up or multiple unsuccessful outreach attempts. Six (6) of 6 files met the requirement for ongoing care plan review. Monitoring of outcomes and revision of the treatment plan as necessary was documented in either the care plan or care coordination notes for 7 of the 7 applicable cases (excluding 3 without sufficient timeframes). Of the 8 applicable behavioral health case management files7 documented monitoring	The plan will educate our staff on the EQRO audit recommendations.

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
					of outcomes. Of the 7 applicable behavioral health case management files, 6 documented revision of the care plan as necessary. **Recommendations** The MCO should ensure that care plans are used to monitor and communicate member outcomes, with revisions made as indicated and communicated to behavioral health and physical health care managers and providers. The MCO should enhance case management interventions for the IET PIP. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.	
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 in the NCM 002 High-Risk Case Management Process Policy and Procedure and in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description.	
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	CM records Member Handbook		Full	This requirement is in the NCM 006 Integration of Physical and BH Care Policy and Procedure, in the CS_WPC_Chronic Illness_Prgrm Mgmt Procedure document, and in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description, and in the Member Handbook for Integrated Health Services.	

Core Benefits and Services						
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	for coordinating Medicaid covered services provided to the member.					
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	-	Substantial	This requirement is addressed in the NCM 006 Integration of Physical and BH Care Policy and Procedure, in the CS_WPC_Chronic Illness_Prgrm Management Procedure document, , in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description, and the Member Handbook for Integrated Health Services; however, it is not clear how this requirement is met for members with physical health or behavioral health benefits, only, per documentation in the Member Handbook for Physical Health Services and in the Member Handbook for Mental Health and Substance Use Treatment. **File Review Results** Of the 9 applicable case management files (excluding 1 with multiple unsuccessful contacts), 9 contained documentation that prevention and treatment services are accessible and comprehensive. Of the 8 applicable case management files (excluding an additional member without indications for referral), 8 met the requirement for referrals as indicated. Of the 8 applicable behavioral health case management files, 8 met the requirement for recording the member's PCP in the care management record or otherwise follow-up. **Recommendation** The MCO should revise the member handbooks for members with either one physical or behavioral health benefits only to	

Core Benefits and Services						
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					explain to members that they are entitled to care coordination and how to access that care coordination. The MCO should improve behavioral case management to ensure that all members have access to comprehensive prevention and treatment services. **Final Review Determination**: No change in determination. There was no MCO Response and Plan of Action..	
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) 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	P/P member Services Call center documentation		Full	This requirement is addressed in the Access Standards_Hours of Operation Policy, in the provider manual on page 34, and The Member Handbook for Integrated Health Services.	
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 CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure, CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure, and CS_WPC_Intensive Opportunity_Prgrm Mgmt Policy and Procedure, as well as in the entitled 2018 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care on page 28. **File Review Results** Of the 10 case management files reviewed, 8 met the requirement for ongoing care coordination, although initial coordination of activities with the Chronic Care Management Program was documented for 10 of 10 files. Five (5) of 7 files with behavioral health	1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care.

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
					conditions received behavioral health care coordination. Eight (8) of 8 applicable files met the requirement for referrals made when necessary. Of the 10 behavioral health case management files, 9 of the 9 applicable files met the requirement for ongoing care coordination, as well as the requirements for coordination of activities with the Chronic Care Management Program as applicable, and for referrals when necessary. Contact was made with the Integrated Medicaid Managed Care Program plan care manager for 10 of 10 files. **Recommendations** The MCO should improve overall care coordination by increasing the involvement of clinical (i.e., RN) care managers (CMs) in order to supplement nonclinical community outreach workers' successful contacts with active member engagement in CM, with communication to local MCO staff in a comprehensive care coordination policy and procedure that is applicable to all members. In addition, the MCO should encourage greater involvement of clinical CMs to tailor the POC to members' individual needs beyond those identified by the member and programmed by the CM software based upon the initial health assessment. The MCO should encourage enhanced clinical CM interaction with to improve POC monitoring and revision by enhancing continuity of clinical care across multiple CM episodes.	

Core Benefits and Services						
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					Final Review Determination: No change in determination. The plan agreed to the recommendation moving forward.	
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 ED staff	Pain management plans P/P for care coordination Includes Care Management File Review UCSMM 04.11 Consumer Safety pg 4		Full	This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure on pages 6 and 7.	
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	P/P for care coordination P/P for PCP choice Member survey Detailed Workflows		Full	The CS_WPC_LA_Care Management Process policy and procedure document and the WPC PD 2019 program description address this overall requirement as it would apply to case management, and the NCM 021 Management of Care Transitions national policy addresses the overall requirement for care transitions between settings for all members and, on-site, the MCO explained that this document addresses transitions in care for all states, including LA. The Member Handbook for Integrated Health Services on page 13 addresses the requirement for member-appropriate provider choice within the MCO. The requirement to conduct member surveys is addressed for members who are engaged in case management in the NCM 002 High-Risk Case Management Process Policy and Procedure, and the conduct of medical and treatment record reviews is addressed in the NCM 021 Management of Care Transitions National Policy on page 2, as well as in the NQM-025 Ambulatory Medical Record	

Core Benefits and Services						
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	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.				Review Process National Policy and Procedure. The UCSMM Policy 06.21 Out of Network Requests and Continuing Care addresses covered services provided out of network.	
6.30.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	P/P for care coordination		Full	This requirement is addressed in the UCSMM02.14 Interdepartmental and External Entity Coordination Policy.	
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 Welcome Call Standard Operating Procedure (SOP).	
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		Substantial	This requirement is addressed in the UHC_CS_WPC_Program Description, and in the member handbook on pages 13 and 14. **File Review Results** Of the 10 case management files reviewed, this requirement was applicable to 9 (excluding 1 file that documented multiple unsuccessful outreach attempts to contact the member). Of the 9 applicable files, 9 met	1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care.

Core Benefits and Services						
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					this requirement. Of the 10 behavioral health case management files reviewed, this requirement was applicable to 8, with 7 of 8 files meeting the requirement for an ongoing source of preventive and primary care; however, release of information from the member/family was obtained to coordinate care with the PCP and other healthcare providers for 8 of 8 applicable files. **Recommendation** The MCO should improve BH follow-up case management to ensure ongoing access to and receipt of comprehensive preventive care. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.	
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 High-Risk Case Management Process and in the CS_WPC_Chronic Illness Program Management Policy and Procedure. Member access to care management as needed is addressed in the member handbook on page 57. This requirement is addressed in the UCSMM02.14 Interdepartmental and External Entity Coordination Policy for out-of-network care, and in the provider manual on page 55. **File Review Results** Ten (10) of 10 case management files met	

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					this requirement.	
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 Management of Care Transitions Policy. In addition, the NCM 006 Integration of Physical and BH Care Policy and the CS_WPC_Chronic Illness_Prgrm Management Policy and the National Policy for Integration of Physical and Behavioral Health Through Whole Person Care address this requirement. This requirement is also addressed in the UCSMM02.14 Interdepartmental and External Entity Coordination and in the NCM 002 High-Risk Case Management Process Policy and Procedure.	
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 UCSMM02.14 Interdepartmental and External Entity Coordination Policy.	
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 UCSMM02.14 Interdepartmental and External Entity Coordination Policy.	
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 NCM 002 High-Risk Case Management Process Policy and Procedure and in the UCSMM02.14 Interdepartmental and External Entity Coordination Policy.	
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 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 30 and 31.	
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 Coordination of BH Care Policy and in the UCSMM02.14 Interdepartmental and External Entity Coordination Policy, as well as in the HIPAA Regulations Authentication Policy and Procedure, and in the National	

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					Policy for Management of Care Transitions.	
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 Discharge Planning Policy.	
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 that:	P/P for care coordination Includes Care Management File Review		Substantial	This requirement is addressed in the Discharge Planning Policy, the RX-046 Automated Transition of Care Policy and Procedure, in the CS_WPC_Transitions of Care Policy and Procedure, and in the Coordination of BH Care Policy and Procedure. **File Review Results** Of the 10 case management files reviewed, 10 met this requirement. Of the 10 behavioral case management files reviewed, there were 8 applicable files (i.e., members with a hospitalization). Of these 8, 5 met the discharge planning requirement. **Recommendation** The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO should address this opportunity in the IET PIP, as well as more broadly for the behavioral health population. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward,	1. The plan will educate our staff on the EQRO audit recommendations. 2. UM includes case management in their bi-weekly meeting. UM care advocates are prompted to include case management when involvement is beneficial for the member -- this has been in place since approximately May 2019. 3. Discharge planning from an interdisciplinary perspective is in place - including inpatient case management, utilization management, and case management. The UM team begins the discharge plan at the time of admission. After reviewing the facility's discharge plan, the UM team can make recommendations if they identify gaps/issues/concerns with the member. High needs

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					with several actions implemented during the current period, although after the review period.	members are being identified through a specific report and addressed in this interdisciplinary process. UM engages in discharge discussions at the beginning of the member's inpatient stay. 4. Training for the case managers was completed July 8th. The training included: • CHW scope of practice o Individuals with a SUD need a referral to a BHA to address SUD component of gaps in care o Referrals and resources related to SUD or other BH needs are best addressed by BHA • Team opportunities field visits o CHWs, RNs, and BHAs can conduct a collaborative field visit in any member's home (especially members with BH needs or SUD) o Leverage technology when possible (Web-ex for virtual visit if BHA not in area/ Chris, Karen and Shelby will need Web-ex access) • Provider access o Live and Work Well for

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						Virtual BH visits • MAT (medication assistance therapy) providers o Medical providers are able to provide MAT • Peer support education o Currently 1 internal PSS to support all of Louisiana (time is split ½ PSS and ½ PSH) o Possible resources for external peer support specialist teams 5. Quality is working with the Community Healthcare Workers to support through education on how to provide members with information when SUD or BH issues are present.
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 addressed in the Utilization Management of Behavioral Health Benefits Policy on page 21.	
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 addressed in the Utilization Management of Behavioral Health Benefits Policy on page 21.	
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	P/P for care coordination		Full	This requirement is addressed in the Utilization Management of Behavioral Health Benefits Policy on page 21.	

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	behavioral health diagnosis occurs timely when the member is not to return home.					
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 member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.	P/P for care coordination Includes Care Management File Review		Full	This requirement is addressed in the Utilization Management of Behavioral Health Benefits Policy on page 21.	
6.30.2.12	Document authorized referrals in its utilization management system;	P/P for care coordination		Full	This requirement is addressed in The CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure and in the member handbook on page 20.	
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 Member Notification_Prov Terms Policy and Procedure.	
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	P/P care coordination Court proceedings		Full	This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure on pages 14 and 15.	

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	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					
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 Utilization Management of Behavioral Health Benefits Policy on page 24.	
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 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 55 and 73-76 and also addresses the PCP's role. The Coordination of BH Care policy does address provision of timely referrals to behavioral health specialists and psychiatrists.	
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	P/P for BH care continuity		Full	This requirement is addressed in the 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 73-76 and in the 2018 Optum Behavioral Health UM Program Description.	

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	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.					
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 with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	P/P for BH care continuity Communication member		Full	This requirement is addressed in the 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 55 and 73-76, and in the Coordination of BH Care Policy.	
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 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on pages 55-56 and 73-76.	
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 provider manual on page 55 and in the Access Standards_Hours of Operation Policy and in the Risk Cases Licensed Optum Clinician Involvement and Supervisory Review-OPS 121918 Policy and Procedure.	
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 LA UHC CP Medicaid UM Policy_1118 Final.	
6.36.7	These procedures must address members with co-occurring medical and behavioral conditions,	P/P for BH care continuity		Full	This requirement is addressed in the CS_PCCM_Med_Behavioral_Case Consult	

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	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.				Policy and Procedure and in the UHC_CS_WPC _Program Description.	
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 CS_Lightning Case Rounds Policy and Procedure and in the CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure.	
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3 6.36.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co- management.	P/P for BH care coordination		Full	This requirement is addressed in the CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure, the Monitoring Collbrtn Btwn BH_Medical Policy and Procedure, the NCM 001 Identification of High-Risk Members for Case Management, the NCM 006 Integration of Physical and BH Care Policy and Procedure, and the NCM 002 High-Risk Case Management Process Policy and Procedure.	
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 Monitoring Collbrtn Btwn BH_Medical Policy and Procedure on page 2. The TelehlthPrvdr Toolkit LA UnitedMedicaid PowerPoint presentation is dated after the review period; however, it does reference a	

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					Telehealth and Telemed reimbursement policy active during the review period, and the MCO-provided documentation addresses this requirement: 6_36_9_1_5_Ntwrk Recruitment_Mngmnt_Virtual visits Policy and Procedure and 6_36_9_1_5_Virtual Visit Reimbursement Policy_BH. On site, the MCO explained that the latter policies apply to all plans, including the LA MCO.	
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 CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure and in the UHC_CS_WPC _Program Description–Program. This requirement is addressed in the Exchange of Info Form.	
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 Member Handbook for Integrated Health Services and in the 07_ProvNtwrok_UHC_LA_EQRO_2019_2017 LA Provider Manual.	
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 CS_WPC_Transitions of Care Policy and Procedure on page 8.	
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 CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure and in the CS_WPC_Transitions of Care Policy and Procedure.	
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 CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure on pages 3 and 4.	

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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 PCPi_ PCP_Final document regarding the Primary Care Professional Incentive Program.	
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 Benefits_EQRO_2019_UHC_LA_LA_Behavior al_Health_Resources and in the Revised_022819_PCA-1-011618-08012018_09062018_LA, as well as the Interim PIP entitled Improving the Quality of Diagnosis, Management and Care Coordination for Children and Adolescents with ADHD (9/28/18) on page 26.	
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 CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure on pages 13 and 16. The MCO also reported that the Optum Whole Person Care team attends monthly meetings, with implementation supported by the Continuum Readmission Follow-Up Report with WPC Impact Review and CM Rounds documentation of meeting dates.	
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 QM17_LDH_CollaborativePIPMeetingNotes_ 07192018.	
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 address in the 040 UHC 2019 A 04 29 2019 and 041 UHC 2019 A reporting documents.	
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 NCM 002 High-Risk Case Management Process Policy and Procedure.	

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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 WPC PD 2019 Program Description and in the NCM 001 Identification of High[Risk Members for Case Management Policy and Procedure.	
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 to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.	P/P for CM		Full	This requirement is addressed in the 2019 CSHealthy First Steps Program Description, NHFSJA 010 Referrals to Healthy First Steps Case Management Program Description, the NHFS Policy 001 Maternity Case Management Policy and Procedure, and the NHFS Policy 002 Identification and Risk Stratification High-Risk Members Policy and Procedure.	
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 WPC PD 2019 Program Description and in the NCM 002 High-Risk Case Management Process Policy and Procedure.	
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 WPC PD 2019 Program Description and in the NCM 002 High-Risk Case Management Process Policy and Procedure.	
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	P/P for CM		Full	This requirement is addressed in the WPC PD 2019 Program Description and in the NCM 002 High-Risk Case Management Process Policy and Procedure.	

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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 NCM 002 High-Risk Case Management Process Policy and Procedure.	
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 WPC PD 2019 Program Description on page 9.	
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 LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019 Report.	
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 LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019 Report.	
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 LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019 Report.	
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 LAPQ39 Reports.	
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 LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019 Report.	
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports		Full	This requirement is addressed in the Pharmacy Lock-In Members 04 2018 - 03 2019.	
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 LA PASSR_Rprt.	
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports		Full	This requirement is addressed in the LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019	

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					Report.	
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 LAPQ039 JAN 2019 Report, the LAPQ039 FEB 2019 Report, and the LAPQ039 MAR 2019 Report.	
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, particularly diagnosed members who are high utilizers of ED and inpatient services.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure, with specification of the listed conditions in the WPC PD 2019 Whole Person Centered Care (WPC) Model Description.	
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 is addressed in the in the WPC PD 2019 Whole Person Centered Care (WPC) Model Description.	
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 040 UHC 2019 A 04 29 2019 and 041 UHC 2019 Reports.	
6.42.4.1	Include the definition of the target population;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the WPC PD 2019 Program Description.	
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 WPC PD 2019 Program Description.	
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 WPC PD 2019 Program Description, the 2019 UHC CPGs_LA document, and the	

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
					NCM 030 Clinical Practice Guidelines Policy and Procedure.	
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 WPC PD 2019 Policy and Procedure.	
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the WPC PD 2019 on page 5.	
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 the WPC PD 2019 on pages 11 and 12.	
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 2019 UHC CPGs_LA document and the WPC PD 2019 Program Description.	
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 WPC PD 2019 Program Description on page 9.	
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 WPC PD 2019 Program Description on page 6.	
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 WPC PD 2019 Program Description on pages 5, 6, and 9.	
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions		Full	This requirement is addressed in the WPC PD 2019 Program Description and in the NCM 034 CC Performance Management Policy and WPC Program Evaluation 2018 Final_UHC LA FINAL.	
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	Communications to LDH		Not Applicable	This report is no longer required.	

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
	sixty (60) days prior to due date of those reports.					
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports		Not Applicable	This report is no longer required.	
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports		Not Applicable	This report is no longer required.	
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 report is no longer required.	
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 WPC Program Evaluation 2018 Final_UHC, an internal document that is noted as "in process." The MCO narrative states, "This report was reviewed by committee 6/13/19 and was submitted to the state 6/18/19."	

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 Network Provider Development 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 Network Provider Development 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 Network Provider Development Management Plan.	
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 Network Provider Development and Management Program.	
7.1.7	The MCO's network providers shall ensure	P/P for Provider Network		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
	physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Access and Availability			Network Provider Development Management Plan on page 14 in Other Enrollment and Disenrollment Requirements, and on page 42.	
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 addressed in the Network Provider Development 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 appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts		Full	This requirement is addressed in the Network Provider Development Management Plan, and through CAHPS surveys and provider satisfaction surveys.	

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
	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						
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 appointment shall be arranged within one (1) hour 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 in the 2017 Care Provider Manual on page 37 , in the 2018 BH Provider Manual on page 22, and the MCO provided results of a sample After-Hours and Appointment Availability Survey to show compliance.	
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	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 2017 Care Provider Manual on page 52. The MCE explained that although the manual says 2017, this manual was utilized and shared with providers for the audited time period. This requirement is addressed in the 2018 BH Provider Manual on page 22.	

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) hours of request;					
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 in the 2017 Care 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 in the 2017 Care Provider Manual, and in the 2018 BH Provider Manual on page 22.	
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 2017 Care Provider Manual on page 37.	
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 2017 Care Provider Manual on page 37.	
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first	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 2017 Care Provider Manual on pages 34 and 37.	

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
	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;					
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 2017 Care Provider manual on page 37.	
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	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 2017 Care Provider Manual on page 38.	
7.3						
7.3.0	The MCO shall comply with the following maximum 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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions		Substantial	This requirement is partially addressed in the Network Provider Development Management on pages 4 to 8. **Recommendation** The MCO should incorporate the new contract language in the Network Provider Development Management Plan. Specifically, the MCO should replace "as determined by LDH approved mapping software" with "as specified in the Provider Network	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH 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
	and provide the findings to LDH as part of its annual Network Provider Development Management Plan.				Companion Guide."	
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 addressed in the Network Provider Development Management on page 4. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The MCO's Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for PCPs, but all rural parishes meet the access standards for both adult and pediatric PCPs. **Recommendation** The MCO should improve access to PCPs for their urban members.	UHC Networks Division will continue its efforts to improve access to PCP's for members located in urban parishes. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
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 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Adequacy standards for distance are mostly met for rural parishes. Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for hospitals. **Recommendation** The MCO should improve access to hospitals for their urban members and improve access for members residing in the rural parish of Tensas.	Currently there are no hospitals located within Tensas Parish. All hospitals in neighboring parishes of Franklin, Madison, and Concordia are contracted with UCCCP. The nearest in-network hospital is located within 32 miles of Tensas parish.

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**
7.3.3 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 partially addressed in the Network Provider Development Management Plan on page 5. Currently, it states, "Travel distance to each specialty type shall not exceed 15 miles and 30 minutes." This is more restrictive than what is listed in the requirement; however, the Q1 2019 Report and a Q4 2018 Gap Analysis Report show evidence that the MCO addresses the requirement language. Approximately 95% or better of members have access to each of the listed specialists within 60 miles of residence. All members are within 60 miles of an Ophthalmologist or Otorhinolaryngology specialist. **Recommendation** The MCO should update the language in the Network Development Plan regarding access to specialists.	UHC will update the Network Development Management Plan to include the specific requirements related to OB/GYN providers as defined in the in the LDH Network Companion guide.
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Most of rural region members are within distance to a lab, but only 45% of members in Tensas Parish have access to a lab within the standards listed. Most of urban region members are within distance to a lab, but only 57% of members in Ouachita Parish have access to a lab within the standards listed.	UHC Networks Division will continue its efforts to improve access to labs for all members with a heightened focus on the parishes of Tensas and Ouachita. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.

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
					Recommendation The MCO should improve access to lab services for all rural and urban members.	
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The access standards are met for rural regions. Most but not all urban regions meet the access standards for pharmacy services. **Recommendation** The MCO should improve access to pharmacy services for all urban members.	UHC Networks Division will continue its efforts to improve access to pharmacy services for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 as proof of compliance. The access standards are met for most rural regions. Some urban regions meet the access standard for pharmacy. **Recommendation** The MCO should improve access to pharmacy services for all rural and urban members.	UHC Networks Division will continue its efforts to improve access to hemodialysis centers for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
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	Network Provider Development and Management Plan P/P for Access and		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least	UHC will update the Network Development Management Plan to include the specific time

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
	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.	Availability GeoAccess reports Requests for exceptions			90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH GeoAccess Report shows that 100% of members have access to BH specialists. **Recommendation** The MCO should update the access standard language on page 6 to address that access to BH specialists should not exceed the 30 miles or 60 minutes for 90% of rural members.	and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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 partially addressed in the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least 90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH Geo Access Report shows that 100% of members have access to BH specialists. **Recommendation** The MCO should update the access standard language on page 6 to address that access to BH specialists should not exceed the 15 miles or 30 minutes for 90% of urban members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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	Network Provider Development and Management Plan P/P for Access and		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report.	UHC will update the Network Development Management Plan to include the specific time

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
	involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Availability GeoAccess reports Requests for exceptions			100% of members have access to Psychiatric inpatient hospitals. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that access to psych hospitals should not exceed the 90 miles or 90 minutes for 90% of members.	and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and 99.8% of rural members have access to ASAM Level 3.3 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and 98.3% of rural members have access to ASAM Level 3.5 providers. **Recommendation** The MCO should update the access standard	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH 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
					language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members.	
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 Requests for exceptions		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and rural members have access to ASAM Level 3.7 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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		Substantial	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and rural members have access to ASAM Level 3.7 WM providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members.	UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.
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.	Network Provider Development and Management Plan		Full	This requirement is addressed in the Network Provider Development Management Plan, as well as 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
	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.	P/P for Access and Availability GeoAccess reports Requests for exceptions			12182018 Appointment Availability Report. 100% of members have access to PRTFs.	
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 requirement is addressed in the Network Provider Development Management Plan on page 8. No request for exception was provided.	
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	This requirement is addressed in the Network Provider Development Management Plan on page 8.	
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	Network Provider Development and Management Plan P/P for Access and Availability Evidence of meeting provider to member ratios		Substantial	This requirement is partially addressed in the Q1 2019 220 Report. Region 6 does not meet ratio standards for allergy, dermatology and endocrinology, specialists. Region 5 does not meet the ratio standard for dermatology, and Region 8 does not meet the standard ratio requirement for endocrinology. **<u>Recommendation</u>** The MCO should recruit enough specialists to meet the ratio standards for specialists across all regions of Louisiana.	UHC Networks Division will continue its efforts to increase the number of specialists within the regions that do not currently meet the standard ratio requirement. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.
7.5						
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	Network Provider Development and Management Plan Provider contracts Provider manual/handbook		Full	This requirement is addressed in the provider manual, the BH provider manual and the Network Development Plan. Additionally, the MCO provided the Appointment Availability survey findings for	

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 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.	P/P for Access and Availability P/P for Monitoring Provider Compliance with Access Standards Plan website Evidence that monitoring was implemented			2018 to show compliance.	
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 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.	GeoAccess reports Communication to LDH/ attestation		Full	This requirement is addressed the 220 and 348 Reports the MCO submits on a quarterly basis.	
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	GeoAccess reports Communications to LDH		Full	This requirement is addressed in the 220 and 348 Reports.	

Provider Network Requirements						
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	shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.					
7.6						
7.6.1	**Provider Participation -**	Provider contracts Network Provider Development and Management Plan P/P for Provider Network				
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. • 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);	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Provider Development Management Plan on page 11. The MCO provided Drafting Tools with the requirement-listed provider types to show compliance.	

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 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 detailing efforts that were made.	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Provider Development Management Plan with BH on page 11.	
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 Network Provider Development Management Plan with BH on page 13.	
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	Network Provider Development and Management Plan P/P for Provider Network		Full	This requirement is addressed in the Network Provider Development Management Plan with BH.	

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
	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)].					
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 Network Provider Development Management Plan with BH on page 13.	
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 Coordination of Care for BH document.	
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					
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 is addressed in the Network Development Plan and the Credentialing Plan.	
7.6.2.2	The MCO shall not contract or shall terminate	P/P for Provider Network		Full	This requirement is addressed in the	

Provider Network Requirements						
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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	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 48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.				Network Development Plan and the Credentialing Plan.	
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 member handbooks.	
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	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention		Full	This requirement is addressed in the Network Development Plan and the Credentialing 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
	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)].	P/P for Provider Credentialing				
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 requirement is addressed in the Network Development Plan, the Credentialing Plan, and the provider manual.	
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		Full	This requirement is addressed in the Network Development Plan.	
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 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.	P/P for Provider Network P/P for Provider Termination Sample notice to members		Full	This requirement is addressed in the Network Development Plan.	
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	P/P for Provider Network P/P for Provider Termination		Full	This requirement is addressed in the 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
	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.	Sample notice to members Member Handbook				
7.7						
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		Full	This requirement is addressed in the Network Development Plan.	
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		Full	This requirement is addressed in the Network Development Plan.	
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 is addressed in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the Network Development Plan.	
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with	P/P provider contracts Provider Contract		Full	This requirement is addressed in the 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
	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	Provider Handbook				
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 in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the 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
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 in the Network Development Plan.	
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 Network Development Plan.	
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 in the Network Development Plan.	
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 in the Network Development Plan.	
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 in the provider manual.	
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts		Full	This requirement is addressed in 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 in 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.					

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
7.8.3.2	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 in the 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		Full	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan and the Geo Access Reports. Additionally, the MCO provided various drafting templates to show compliance.	
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 in the Network Development Plan. Member-to-provider ratios are reported in the 220 Reports.	

Provider Network Requirements						
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7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	P/P for Provider Network P/P for Access to Specialty Providers P/P for direct access services		Full	This requirement is addressed in the Network Development Plan.	
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 is addressed in the Network Development Plan.	
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 in the Network Development Plan. The MCO has produced a gap analysis finding on hospital access for urban and rural parish members, and will contract with out-of-state hospitals if necessary.	
7.8.4.4	If there are no hospitals within the parish that	P/P for Provider Network		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
	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.	GeoAccess reports			Network Development Plan. The MCO has produced a gap analysis finding on hospital access for urban and rural parish members, and will contract with out-of-state hospitals if necessary.	
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	P/P for use of out-of-network providers P/P for providing access to tertiary care GeoAccess reports		Full	This requirement is addressed in the Network Development Plan.	
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 Network Development Plan.	
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 Network Development Plan. The MCO is contracted with the Office of Public Health for all health and family planning clinics.	
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	P/P for direct access services Member Handbook		Full	This requirement is addressed in the 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
	unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.					
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 Network Development Plan.	
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 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	P/P for Prenatal Care Services Access P/P for Assignment of PCPs including Auto Assignment		Full	This requirement is addressed in the Network Development Plan.	

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	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.					
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Evidence of availability of other medical service providers		Full	This requirement is addressed in the Network Development Plan.	
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 Network Development Plan. The MCO provided a sample Drafting Tool for FQHC to show compliance.	
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 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 Network Development Plan.	
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	P/P for Provider Network Contract with Louisiana OPH		Full	This requirement is addressed in the Network Development Plan.	

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	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.					
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring 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.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Network Development Plan.	
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 Network Development Plan.	
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			Full	This requirement is addressed in the Network Development Plan.	

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	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.					
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 in the Network Development Plan.	
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 providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the 2019 Optum response on Freedom of Choice forms. It is required to be in member charts and is subject to audits.	
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 in the 339 Report for Q1 2019.	
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	P/P provider network P/P care coordination Network reports		Non-compliance	This requirement is not met as discussed on the 348 Report on Crisis Stabilization for Q1 2019; the MCO do not have crisis specialist type providers in their network. However, the MCO is currently addressing this gap in provider coverage by researching opportunities within their provider network to opening this level of care in the community. The MCO mentioned they have one signed letter of intent with Start Corporation to operate the Safe Haven	UHC will continue to reach out to providers to expand levels of care and collaborate with LDH and fellow MCOs to expand the network as possible. Opportunities to expand care with crisis centers and community based alternatives to emergency room use will continue.

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	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 provided and reimbursed through the MCO, including meals and lodging as appropriate.				Center when it opens in St. Tammany. At UHC's suggestion, the 5 MCOs in LA are collaborating to strategize on developing the CS network for youth and adults. Single case agreements and transportation reimbursements are discussed in the Provider Network Development Plan. **Recommendation** The MCO should continue with their efforts to ensure members have access to crisis stabilization providers and seek to expand or grow this provider type within their provider network.	Provider availability for Emergent and Urgent situations are monitored quarterly as part of the 359 report to ensure availability exceeds the threshold of 90%.
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 mentioned in the BH Provider Manual.	
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 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 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	P/P provider network P/P care coordination Network reports		Non-compliance	This requirement is addressed in the Network Development Plan. The MCO contracts with all sorts of provider types. However, the MCO noted in a follow-up response to the audit that the only Indian	UHC Networks Division will continue its recruiting efforts with Indian Health Clinics. Provider ethnicity that is captured within the

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	providers for Indian members who are eligible to receive services.				Health Clinic approved by the state has refused to join their network. However, members may seek care at this clinic and the clinic is reimbursed at the state-assigned encounter rate for all covered services. The MCO noted that the printed provider directory informs members of the provider's Native American status; however, the example provided is not evidence of a provider as an IHCP. The provider example the MCO pointed out is a doctor of Indian (from India) origin, not Native American. In review of the online provider directory, one cannot identify Native American Providers. **Recommendation** The MCO should try to enroll IHCPs and Indian Health Clinics into their provider network, and ensure that their Native American membership can find access to IHCPs in the provider directory online.	UHC Online Provider Directory is a self-reported field. UHC will work with its provider network to encourage the submission of demographic data needed to assist Native American membership with locating the physician of their choice.
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					

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	under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled 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.			Full	This requirement is addressed in the Network Development Plan.	
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 addressed in the Network Development Plan.	
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: .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).	P/P provider network P/P care coordination Network reports		Full	This requirement is addressed in the Network Development Plan.	
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 addressed in the Network Development Plan.	
7.9						
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	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	

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	written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.68):					
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services	Provider Network Development and		Full	This requirement is addressed in the Network Development Plan.	

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	that is adequate for the anticipated number of members in the service area;	Management Plan				
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
7.9.2.7	Timely Access	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
7.9.2.8	Service Area	Provider Network Development and Management Plan		Full	This requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan.	
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 requirement is addressed in the Network Development Plan and a Gap Analysis Report.	
7.9.3.1	The MCO shall ensure network capacity sufficient	Provider Network		Full	This requirement is addressed in the	

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	to meet the specialized needs of individuals with 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.	Development and Management Plan			Network Development Plan.	
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	This requirement is addressed in the website directory for DSNP providers.	
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 in the 220 and 348 Reports the MCO produces.	
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
7.9.5.3	Evaluate the quality of services delivered by the network;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan.	
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan.	

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	service area;					
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
7.9.5.7	Provide training for its providers and maintain records of such training;	P/P for Network Development and Management		Full	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	

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7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to 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.	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
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	This requirement is addressed in the Network Development Plan.	
	• 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	This requirement is addressed in the Network Development Plan.	
	• 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	Network development Implementation plan P/P provider network		Full	This requirement is met by the 220 and 348 Geo Access Reports.	

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	and coding to LDH quarterly by contract year, 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	This requirement is addressed in the Network Development Plan.	
	• 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	Network development Implementation plan P/P provider network		Full	This requirement is addressed in the Network Development Plan.	

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	considering distance, travel time, and available means of transportation; o Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.					
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	This requirement is addressed in the Network Development Plan.	
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	Network development and management plan		Full	This requirement is addressed in the 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
	comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.					
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	Network development and management plan		Full	This requirement is addressed in the 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
	• Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.					
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the providers on an ongoing basis, at least 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	Network development and management plan		Full	This requirement is addressed in the 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
	including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network development and management plan		Full	This requirement is addressed in the Network Development Plan.	
7.11						
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.	Evidence of communications with LDH P/P provider contracting		Full	This requirement is addressed in the 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
	• A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.					
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in 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 Network Development Plan.	
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 Network Development Plan.	
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 Network Development Plan.	
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.					

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
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid 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.	Notification to LDH P/P provider network		Full	This requirement is addressed in the Network Development Plan.	
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 Network Development Plan.	
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%);	Evidence of notifications P/P provider network		Full	This requirement is addressed in the Network Development Plan and the Medicaid Addendum on Network Development.	

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
	• A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential 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 Network Development Plan.	
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	Request for approval letter		Full	This requirement is addressed in the 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
	legal guardian to discuss available options and 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 Network Development Plan.	
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 Network Development Plan.	
7.12						
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 Network Development Plan.	
7.13						
7.13.2.2	The MCO provider selection policies and	P/P for Network		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
	procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Management P/P for Provider Selection and Retention			Network Development Plan and in the Provider Contract language.	
7.14						
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 Network Development Plan, the Narrative for Items, and several credentialing policies.	
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	P/P provider contracting		Full	This requirement is addressed in the Narrative for Items.	

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
	credentialing file with the MCO. Agencies not 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	This requirement is addressed in the Narrative for Items, and review of UHC credentialing forms verifies they use the standard credentialing forms. Delegated credentialing partners may use their own forms but data elements required for credentialing verification are captured. On-site file reviews verified the MCO follows 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-	

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
					certifications if applicable, current licenses, valid DEA/CDS certifications if any, and the attestation. For recredentialing files, if board certifications were not applicable to provider specialty types, then education was verified by the staff. **Credentialing File Review Results** Five (5) out of 5 files met the standards for credentialing verification. **Re-credentialing File Review Results** Five (5) out of 5 files met the standards for re-credentialing verification.	
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review		Full	This requirement is addressed in the Narrative for Items.	
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 requirement is addressed in several of the MCO's Credentialing and Delegation Policies.	
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 Narrative for Items. **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	P/P for credentialing &		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
	its provider files in its claims processing system; and	recredentialing			Narrative for Items.	
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 a submission report (Jan 21 2019).	
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 Narrative for Items.	
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 by the Delegation Agreement.	
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 addressed in the Addendum to Credentialing Policies.	
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 by the Provider Adds and New Contracts Policy.	
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 FWA Compliance Plan.	
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing 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
		Includes Credentialing/Recredentialing File Review			**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 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.	P/P for credentialing & recredentialing		Full	This requirement is addressed in the Credentialing Plan.	
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 several policies that UHC has for the provider network, such as those for disciplinary action, threat to patient safety, and adverse action reporting.	
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	The requirement is addressed in the Provider Network 179 Narrative and Quality of Care Appeal 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
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.					
7.16						
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 Network Development Plan.	
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 Network Development Plan.	
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 Network Development Plan.	
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 Network Development Plan.	
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 Network Development Plan.	
7.16.1.5	Any MCO that violates the anti-gag provisions set					

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
	forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.					
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts Member Handbook		Full	This requirement is addressed in the Network Development Plan.	

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 Utilization Management Program Description. At the onsite UHC discussed the process that UM Program Description and policies and procedures are submitted annually to LDH for approval. Compliance department submits to LDH an attestation using LDH form that it is not more restrictive than the state program. All changes are submitted to LDH.	
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 in the UCSMM 06.10 Clinical Review Criteria policy on page 4 and the Clinical Criteria Development policy and Utilization Management Program Description.	
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 UCSMM 06.10 Clinical Review Criteria policy and the Clinical Criteria Development policy and the Utilization Management Program Description.	
8.1.2.3	Are considerate of the needs of the members; and	P/P for UM		Full	This requirement is addressed in the UCSMM 06.10 Clinical Review Criteria policy on page 4 and the Clinical Criteria Development policy and Utilization Management Program Description.	
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	P/P for UM		Full	This requirement is addressed in the UCSMM 06.10 Clinical Review Criteria policy on page 4 and the Clinical Criteria Development policy and the Utilization Management Program Description. In addition, UHC	

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
					submits all policies to LDH annually and when updated for review and approval.	
8.1.3	The policies and procedures shall include, but not be limited to:					
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	P/P for UM		Full	This requirement is addressed in the UCSMM 06.10 Clinical Review Criteria policy on page 2 and the Clinical Criteria Development policy and the Utilization Management Program Description.	
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 Clinical Review Criteria policy and Clinical Criteria Development policy.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	P/P for UM		Full	This requirement is addressed in the Clinical Review Criteria policy and the Utilization Management 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 Clinical Review Criteria policy and the Utilization Management Program Description.	
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 Utilization Management 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 Utilization Management Program Description.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	P/P for UM		Full	This requirement is addressed in the Utilization Management Program Description.	
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 Utilization Management Program Description.	
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	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the LA UHC CP Medicaid Utilization Management Policy in section M.6.	

Utilization Management						
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	behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;					
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	P/P for UM P/P Coordination of services		Full	This requirement is addressed in the LA UHC CP Medicaid Utilization Management Policy in section M.7.	
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 LA UHC CP Medicaid Utilization Management Policy in section M.8.	
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 LA UHC CP Medicaid Utilization Management Policy in section M.9.	
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 address through the submission of the UHC Provider Advisory committee Minutes. The LA Medicaid MCOs meet regularly to create policy consensus. MCO association meets regularly. LDH required all MCOs us the same CPG.	
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 Provider Manual.	
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted	Provider contracts Compliance reports		Substantial	This requirement is partially addressed in the Clinical Practice Guidelines and the Provider	The health plan agrees with the recommendation. The

Utilization Management						
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	specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.				Manual. UHC provided reports documenting the tracking of the rates. However, they were not achieving the 80% compliance rate. **Recommendation** The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	health plan will promote the use of Clinical Practice Guidelines with incentives to improve compliance to 90% or higher.
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 UCSMM 06.10 Clinical Review Criteria policy and the LA UHC CP Medicaid Utilization Management Policy in section 1.f.	
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 UCSMM 06.10 Clinical Review Criteria policy and the LA UHC CP Medicaid Utilization Management Policy in section 1.f.	
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 UCSMM 06.10 Clinical Review Criteria policy and the LA UHC CP Medicaid Utilization Management Policy in section 1.f.	
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 UCSMM 06.10 Clinical Review Criteria policy, the LA UHC CP Medicaid Utilization Management Policy in section 1.f and the UM Program Description.	
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 UCSMM 06.10 Clinical Review Criteria policy and the LA UHC CP Medicaid Utilization Management Policy.	
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	P/P for UM P/P for guideline dissemination		Full	This requirement is addressed in the UCSMM 06.10 Clinical Review Criteria policy and the LA UHC CP Medicaid Utilization Management Policy. The clinical guidelines are posted to the UHC website.	

Utilization Management						
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	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.					
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	P/P for UM P/P for required information P/P for additional information		Full	This requirement is addressed in the Information Based Clinical Review policy and the UHC CP LA Medicaid Utilization Management Policy.	
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release 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 UCSMM 6.19 Information Based Clinical Review and LA UHC CP Medicaid Utilization Management Policy on page 18.	
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 UCSMM 06.10 Clinical Review Criteria and LA UHC CP Medicaid Utilization Management Policy on page 2.	
8.1.11	The MCO shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana	P/P for UM		Full	This requirement is addressed in the UCSMM 06.10 Clinical Review Criteria and the LA UHC	

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	Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.				CP Medicaid Utilization Management Policy– section IV	
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 UCSMM 6.15 Peer Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
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 UCSMM 6.15 Peer Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	P/P for UM Includes UM File Review		Full	This is requirement is addressed In the UCSMM 6.15 Peer Clinical Review and LA UHC CP Medicaid Utilization Management Policy in section 2. **UM Denial File Review Results** Ten (10) of 10 were compliant	
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 UCSMM 6.15 Peer Clinical Review policy.	
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 UCSMM 6.15 Peer Clinical Review And LA UHC CP Medicaid Utilization Management Policy in section 2	
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care	P/P for UM		Full	This requirement is addressed in the UCSMM 06 10 Clinical Review Criteria policy and the	

Utilization Management						
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	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 with 42 CFR §438.210.				UHC CP LA Medicaid Utilization Management Policy. It is also addressed by the Utilization Management of Behavioral Health Benefits Policy in section IV. Onsite. Pre-authorization to prevent un-needed services. Use nationally accepted criteria to ensure members are getting proper services.	
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 UCSMM 02 12, Performance Assessment and Incentives and the UHC CP LA Medicaid Utilization Management Policy and the Utilization Management of Behavioral Health Benefits in section IV.	
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 addressed in the UCSMM 06 16 Initial Review Timeframes and the UHC CP LA Medicaid Utilization Management Policy. It is also addressed in the Utilization Management of Behavioral Health Benefits in section IV.	
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,	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UCSMM 6.14 Initial Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	

Utilization Management						
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	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:					
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 UCSMM 6.14 Initial Clinical Review policy, LA UHC CP Medicaid Utilization Management Policy and UM Program Description.	
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 UCSMM 6.14 Initial Clinical Review policy, LA UHC CP Medicaid Utilization Management Policy and UM Program Description.	
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	P/P for UM P/P for service authorization		Full	This requirement is addressed in the UCSMM 6.14 Initial Clinical Review policy, LA UHC CP Medicaid Utilization Management Policy and UM Program Description.	
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 Integrated Member Handbook on page 21.	
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 through the submission of authorization system screenshots.	
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	P/P for UM P/P for service authorization		Full	This requirement is addressed through the submission of authorization system screenshots.	

Utilization Management						
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	support the decision, and time frames for notification of providers and members of decisions.					
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 the UCSMM 6.14 Initial Clinical Review policy, LA UHC CP Medicaid Utilization Management Policy and UM Program Description.	
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 Common Observation Policy.	
8.4.5	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals.	P/P prior authorization P/P for UM		Full	This requirement is addressed in the UCSMM 6.14 Initial Clinical Review Policy and the UCSMM Policy 06.19 Information Based Clinical Review.	
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 25 and LA UHC CP Medicaid Utilization Management Policy – section D.1 page 8	
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	P/P for UM		Full	This requirement is addressed in the Behavioral Health Utilization Management Program Description.	

Utilization Management						
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	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.					
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, 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	P/P for UM Evidence of timely submissions Notification communication to member/provider		Full	This requirement is addressed in the Behavioral Health Utilization Management Program Description.	

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	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 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					

Utilization Management						
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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 Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy.	
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 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).	P/P for UM LMHP Subcontract		Full	This requirement is addressed in the Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy.	
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 Standard Operating Procedure Certification/ Recertification of PRTF Services in Louisiana policy.	
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	P/P certification Tracking report P/P for UM Hospital reports		Substantial	This requirement is partially addressed in the Standard Operating Procedure Certification/Recertification of PRTF services. However, the new contract language is not included. **Recommendation** The MCO should incorporate the new contract language into the standard operating procedure.	The plan agrees and has updated its document to include the contractual language in this section.

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	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 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-					

Utilization Management						
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	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 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.	P/P for UM P/P for standard service authorization		Full	This requirement is addressed in the UCSMM 6.16 Initial Review Timeframes policy.	
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 UCSMM 6.16 Initial Review Timeframes policy.	
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	P/P for UM P/P for concurrent review determinations		Full	This requirement is addressed in the UCSMM 6.16 Initial Review Timeframes policy.	

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	within two (2) business days of obtaining the appropriate medical information that may be required.					
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 request for service.	P/P for UM P/P for expedited service authorization		Full	This requirement is addressed in the UCSMM 6.16 Initial Review Timeframes policy.	
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 UCSMM 6.16 Initial Review Timeframes policy.	
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 UCSMM 6.16 Initial Review Timeframes policy.	
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 UCSMM 6.16 Initial Review Timeframes policy.	
8.5.4	**Timing of Notice**					
8.5.4.1	**Notice of Action**					
8.5.4.1.1	**Approval [Notice of Action]**					

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
8.5.4.1.1.1	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 UCSMM 6.16 Initial Review Timeframes policy. **UM Denial File Review Results** Ten (10) of 10 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 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.	P/P for UM P/P for notice timing		Full	This requirement is addressed in the UCSMM 6.16 Initial Review Timeframes policy.	
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 LA UHC CP Medicaid Utilization Management Policy. **UM Denial File Review Results** Ten (10) of 10 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	P/P for UM P/P for notice timing Includes UM File Review		Full	This requirement is addressed in the UCSMM 6.16 Initial Review Timeframes policy. **UM Denial File Review Results** Ten (10) of 10 were compliant	

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 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.					
8.5.4.1.3	**Informal Reconsideration**					
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	P/P for UM P/P for informal reconsideration		Full	This requirement is addressed in the UCSMM 6.15 Peer Clinical Review policy and LA UHC CP Medicaid Utilization Management Policy.	
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 Includes UM File Review		Full	This requirement is addressed in the UCSMM 6.15 Peer Clinical Review policy and LA UHC CP Medicaid Utilization Management Policy. This is addressed in the member/provider notification letter. **UM Denial File Review Results** Ten (10) of 10 were compliant.	
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 UCSMM 6.15 Peer Clinical Review policy and LA UHC CP Medicaid Utilization Management Policy. **File Review Results** Two (2) of 5 were compliant Per LDH the MCOs are being held accountable for the 1 day turnaround. **Recommendation** UHC should ensure that the informal reconsideration is resolved within 1 working	

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
					day.	
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 UCSMM 6.15 Peer Clinical Review policy and LA UHC CP Medicaid Utilization Management Policy.	
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 UCSMM 4.11 Consumer Safety policy and LA UHC CP Medicaid Utilization Management Policy, and in the Member handbook, pages 22 and 24.	
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 UCSMM 4.11 Consumer Safety policy.	
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			This requirement is addressed in the Member handbook 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 Transition of Care for Members of New Optum Groups Receiving Behavioral Health Care Services policy.	
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Transition of Care for Members of New Optum Groups Receiving Behavioral Health Care Services policy.	
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 the Provider Manual.	
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	P/P for UM P/P for exceptions		Full	This requirement is addressed in the Member Handbook.	

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
8.5.4.2	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 the Provider Manual.	
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 the Provider Manual.	
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 the provider manual on page 5.	
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 the UCSMM 6.19 Information Based Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the UCSMM 6.19 Information Based Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	P/P for UM Provider Manual/Handbook Provider contracts		Full	This requirement is addressed in the UCSMM 6.19 Information Based Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by 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 the UCSMM 6.19 Information Based Clinical Review and LA UHC CP Medicaid Utilization Management Policy.	
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**					
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	PCP/BN profiling report		Full	This requirement is partially addressed via the discontinued profiling reports as evidence. This requirement is met addressed through	The health plan does review PCP and Behavioral Health utilization data reports. Evidence for this was submitted in Section

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 submission of the Excel spreadsheet titled "PCR_PCP_CH3_TIN_Report_for_LA"'. **Final Review Determination** This determination is changed to Full based on UHC pointing out the report that was previously submitted with the preonsite documentation.	8.1.2.1, PCR_PCP_CH3_TIN_Report_for_LA.
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 Adverse Incident Reporting Policy.	
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 LA UHC CP Medicaid Utilization Management Policy on page 25.	

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.	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy.	
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	Policy for Member Disenrollment		Substantial	This requirement is addressed in the disenrollment policy. The first two bullets are not addressed in the member handbooks. Post-onsite, a member newsletter and integrated welcome letter included language on member rights, and makes reference to member services should members need assistance in addressing concerns. **Recommendation** The MCO should incorporate the language of the contract into the member handbooks so that members are directly informed of their disenrollment rights.	This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.

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).	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy. All three member handbooks discuss that members can opt out of the plan within the first 90 days of enrollment into another plan or during the open enrollment period.	
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Policy for Member Disenrollment		Substantial	This requirement is addressed in the disenrollment policy. Members are encouraged to call the Enrollment Broker, whose number is listed in all three handbooks. However, there is no explicit reference to this as the Enrollment Broker's contact number. Members should be directly informed that is who they need to reach out to with disenrollment requests. **Recommendation** The MCO should update the written language in the handbook(s) to state that members (or their representative) must contact the Enrollment Broker, and the number listed in the book is in reference to	This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.

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
					the Broker.	
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.	Policy 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 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)).	Policy for Member Disenrollment Member Notification Letter		Full	This requirement is addressed in the disenrollment policy.	
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.	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy. Provided after the onsite was an explanation of disenrollment due to death or incarceration.	
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;	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy.	
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	Policy 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
	requested disenrollment, the reason for the request, and the effective date.					
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy.	
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.	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy. Evidence of disenrollment data being maintained in an identifiable format is addressed in the post-onsite document Enrollment Disenrollment Response.	
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.	Policy for Member Disenrollment		Full	This requirement is addressed in the disenrollment policy.	
11.11.4.8	The Enrollment Broker debwill 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.	Policy 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 writings 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.	Policy for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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.					

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
12.9.4	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.	Policy for Written Member Materials Guidelines Policy for Disclosure of Financial Interest		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	Policy for Written Member Materials Guidelines Policy for Compliance with "Person First" Policy Sample written member materials including Member Handbook		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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.	Policy for Written Member Materials Guidelines Sample written member materials		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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;	Policy for Written Member Materials Guidelines Policy for Informing Members/Potential Members of Interpretation Services		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10.	
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.	Policy for Written Member Materials Guidelines Sample written member materials including Member Handbook		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10 and the Member Handbook on page 13.	
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These	Policy for Written Member Materials Guidelines Policy for Informing Members/Potential Members of Access to Alternative Forms of		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on pages 9 and 10 and the Member Handbook in	

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
	alternatives must be provided at no expense to the member.	Communication			the introduction.	
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.	Policy for Member Education Policy for Member Disenrollment Policy for Member Enrollment Policy for Member Re-enrollment		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 11.	
12.11.3	**Member Materials and Programs for Current Enrollees**					
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 13 and examples of member education materials. In addition, a link to the UHC website was provided.	
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/newsletter		Full	This requirement is addressed through the submission of the UHC Spring and Fall 2018 newsletters.	
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion	Brochures and other examples of literature including EPSTD materials		Full	This requirement is addressed through the submission of the Annual Wellness Adult and Children and EPSDT Outreach	

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
	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;				Materials.	
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN		Full	This requirement is addressed in the UHC Member Education policy – Required Materials on page 13 and the submission of Chronic Disease & Special Health Care Materials. These materials are also distributed via community events and based on member chronic diseases.	
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials		Full	This requirement is addressed in the UHC Member Education policy – Required Materials on page 13 and the submission of the UHC Heart Health Guide.	
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 UHC Member Education policy – Required Materials on page 13 and the submission of the Self Help brochure.	
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 UHC Member Education policy – Required Materials on page 13 and a document with several health fair brochures.	
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 in the UHC Member Education policy – Required Materials on page 13 and a document with several at risk condition brochures.	
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for	Example Member education material		Full	This requirement is addressed in the UHC Member Education policy – Required Materials on page 13 and the Diabetes and Eyes brochure.	

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
	various illnesses and/or exacerbations related to that disability or disabilities;					
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 Policy for member education		Full	This requirement is addressed in the UHC Member Education policy – Required Materials on page 14.	
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	Policy for member education		Full	This requirement is addressed in the UHC Member Education policy – Required Materials on page 14.	
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 through the submission of the member handbook's Integrated Health Services, Physical Health Services, and Mental Health and Substance Use.	
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		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services, Physical Health Services and Mental Health and Substance Use.	
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	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services, Physical Health Services, and Mental Health and Substance Use.	

Marketing and Member Education						
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	termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;					
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services and Physical Health Services.	
12.12.1.5	Member's right to select and change PCPs within the MCO and how to do so;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services and Physical Health Services.	
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services and Physical Health Services.	
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 through the submission of the member handbook's Integrated Health Services, Physical Health Services, and Mental Health and Substance Use.	
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 through the submission of the member handbook's Integrated Health Services	
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services, Physical Health Services, and Mental Health and Substance Use.	
12.12.1.10	Description on the purpose of the Medicaid	Member Handbook		Full	This requirement is addressed through	

Marketing and Member Education						
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	card and the MCO card and why both are necessary and how to use them;				the submission of the member handbook's Integrated Health Services. Information is also included in the new member packet.	
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		Substantial	This requirement is partially addressed through the member handbook. The MCO provided a screenshot of a Member and Provider Call Centers via screen via their Benefit Matrix showing it is available through both in and out of network. However, an explanation should be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. **Recommendation** The MCO should include information in the member handbook explaining that the MCO cannot require the enrollee to obtain a referral before choosing family planning provider.	This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019.
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services.	

Marketing and Member Education						
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	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 through the submission of the member handbook's Integrated Health Services.	
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 through the submission of the member handbook's Integrated Health Services.	
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with LDH;	Member Handbook		Full	This requirement is addressed in the Member Handbook for Integrated Services on pages 39-41.	
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 through the submission of the member handbook's Integrated Health Services.	
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	Per the member handbook, UHC does not have services that are not covered because of moral or religious objections.	
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 through the submission of the member handbook's Integrated Health Services.	
12.12.1.19	Grievance, appeal and fair hearing	Member Handbook		Full	This requirement is addressed through	

Marketing and Member Education						
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	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 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.				the submission of the member handbook's Integrated Health Services.	
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	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services and the Advance Care Planning policy.	

Marketing and Member Education						
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	state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.					
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 through the submission of the member handbook's Integrated Health Services.	
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 through the submission of the member handbook's Integrated Health Services.	
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 through the submission of the member handbook's Integrated Health Services.	
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook		Full	This requirement is addressed through the submission of the member	

Marketing and Member Education						
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					handbook's Integrated Health Services.	
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services.	
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 through the submission of the member handbook's Integrated Health Services on page 64.	
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 through the submission of the member handbook's Integrated Health Services on page 60.	
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information 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;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services on page 64.	
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 through the submission of the member handbook's Integrated Health Services on page 59.	
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 through the submission of the member handbook's Integrated Health Services on page 21.	
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	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services	

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	established for that purpose;				on page 62.	
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook		Full	The MCO noted there is no additional text provided by LDH as deemed essential.	
12.12.1.33	The date of the last revision;	Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services 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 through the submission of the member handbook's Integrated Health Services on page 61.	
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 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	Member handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services.	

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	• 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 through the submission of the member handbooks Integrated Health Services on page 60.	
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 in the UHC Member Education policy – Required Materials policy on page 16.	
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;			Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 16.	
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 UHC Member Education policy – Required Materials policy on page 16.	
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 UHC Member Education policy – Required Materials policy on page 16.	
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 UHC Member Education policy – Required Materials policy on page 16.	
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 UHC Member Education policy – Required Materials policy on page 16 and the Spring 2018 member newsletter.	
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The	Dated revision of member handbook		Full	This requirement is addressed in the UHC Member Education policy –	

Marketing and Member Education						
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	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.				Required Materials policy on page 16 and the revised date of the member handbook on the cover page.	
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	Policy for Provider Directory Provider Directory		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 19. In addition, a hardcopy was provided. The website has a provider directory search option.	
12.14.1.1	A hard copy directory, when requested, for members and potential members;	Policy for Provider Directory Provider Directory (hard copy)		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 16 and submission of the provider directory.	
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	Policy for Provider Directory Provider Directory (website link)		Substantial	This requirement is partially addressed through the web URL that was submitted for the provider directory. A web-based machine-readable version is not available. **Recommendation** The MCO should make available a web-based machine-readable version.	UHC has initiated Accessibility procedures for new documents (like Member Handbooks) or document updates. The Plan will have all web-based machine readable content available by 12/31/19.
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	Policy for Provider Directory Provider Directory (electronic file format)		Full	This requirement is addressed through the submission of a screenshot showing provider file submission to the LDH website.	
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	Policy for Provider Directory Provider Directory (abbreviated hard copy)		Full	Enrollment has provided the entire file and will provide an abbreviated version if needed.	
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	Policy for Provider Directory		Full	This requirement is addressed in the UHC Member Education Required Materials policy on page 19. The	

Marketing and Member Education						
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	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.				provider directory web search is updated monthly.	
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;	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Substantial	This requirement is addressed in the hardcopy provider directory as well as the online version. However, website URLs and the provider's cultural competency training are not included. **Recommendation** The MCO should include both the website URL and the provider's cultural competency training in their directory.	The Plan agrees and will include both the website URL and the provider's cultural competency training in the directory.
12.14.4.2	Identification of qualified providers divided into specific provider and service types and	Policy for Provider Directory Provider Directory (full hard copy, website		Full	This requirement is addressed through the submission of the hardcopy	

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	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;	version, electronic file, abbreviated hard copy)			provider directory.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 19 and submission of the provider directory.	
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).	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)		Full	This requirement is addressed through the submission of the provider directories.	
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.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed in the member handbook and Member Rights and Responsibilities Standard Operating Procedure.	
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Policy for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services	

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		Provider Manual Provider Contract Contractor Contract			on page 63.	
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.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services on page 64.	
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	Policy for Member Rights and Responsibilities Member Handbook		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services on page 64.	

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	care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up 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.	Policy for Provider Termination Policy for notifying members of provider termination		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 23.	
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	Policy for Provider Termination Policy for notifying members of provider termination		Full	This requirement is addressed in the UHC Member Education policy – Required Materials policy on page 23.	

Marketing and Member Education						
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	occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.					
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.	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the services		Full	This requirement is addressed through the submission of the member handbook's Integrated Health Services on page 59. In addition, the Language Line SOP And Hearing and Speech Impaired or Disabled Call Handling SOP was provided as evidence.	
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	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the services	Language Line SOP Hearing and Speech Impaired or Disabled Call Handling SOP	Full	This requirement is addressed through the UHC website. The website is able to translate based on language chosen. English and Spanish are predominant. Vietnamese is only 2%.	

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
	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).					
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 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.	Policy for Member Rights and Responsibilities			This requirement is addressed in the UHC Member Education Policy and Procedure Required Materials policy on page 24 and the member handbook on page 59.	

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.	Policy for Grievances Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance 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.	Policy for Grievances Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
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.	Policy for Grievances Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
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.	Policy for Grievances Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in	Policy for Grievances		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and	

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.				Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
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.	Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
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.	Policy for Grievances Policy for Appeals Policy for Fair Hearing		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy and the Member Handbook in the Grievance and Appeals section.	
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 which arise from it or until the end of the regular ten (10) year period, whichever is later.	Policy for Grievances Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Recordkeeping section.	
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	Policy for monthly reporting of grievances and appeals including sample report format		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Recordkeeping section.	

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
	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.					
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.	Policy for Adverse Decisions		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the LDH Intervention section.	
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;	Policy for Grievances Policy for Appeals Acknowledgement Letter Template Includes Member Grievance File and Member Appeal File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Acknowledgement sections. **Grievance File Review Results** Fifteen (15) of 15 were compliant. **Appeal File Review Results** Ten (10) of 10 were 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;	Policy for Grievances Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Assistance sections. This language is also in the acknowledgement and resolution letters.	
13.4.1.3	Ensure that the individuals who make decisions on	Policy for Grievances		Full	This requirement is addressed in the	

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
13.4.1.3.1 13.4.1.3.2 13.4.1.3.3	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.	Policy for Appeals Includes Member Grievance File and Member Appeal File Review			Member Appeal, State Fair Hearing and Grievance Policy in the Reviewer sections. **Grievance File Review Results** Fifteen (15) of 15 were compliant for not being involved in any previous level of review or decision-making. Two (2) of 2 were complaint for reviewer being a health care professional with appropriate expertise since these were administratively related. 13 were NA due to it being an administrative grievance. **Appeals File Review Results** Ten (10) of 10 were compliant for not being involved in any previous level of review or decision-making. Ten (10) of 10 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 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.	Policy for Appeals Member Handbook Confirmation Letter Template		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Non-expedited Oral Appeal Requests section.	
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in	Policy for Appeals Member Handbook		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and	

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
	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).	Process for notifying member of opportunity to provide evidence Includes Member Appeal File Review			Grievance Policy in the Evidence sections. **Appeals File Review Results** Ten (10) of 10 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.	Policy for Appeals Member Handbook Process for notifying member of opportunity to examine case file Includes Member Appeal File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Evidence sections. **Appeals File Review Results** Ten (10) of 10 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.	Policy for Appeals Member Handbook Includes Member Appeal File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Evidence sections. **Appeals File Review Results** Ten (10) of 10 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 through the submission of the training narrative. Separate trainings for new staff (4 month training). There would be supplemental training if there are new requirements.	
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 Quality program description page 11.	
13.4.5	**Failure to Make a Timely Decision** Appeals shall be resolved no later than stated	Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and	

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
	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.				Grievance Policy in the Failure to Make a Timely Appeal Decision section.	
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.	Policy for Appeals Policy for Fair Hearing Appeal Resolution Notice		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Notice of Appeal Resolution section.	
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 Member Appeal, State Fair Hearing and Grievance Policy in the Resolution: Notice of Appeal Resolution section and the Initial Adverse Determination Notice policy. **Grievance File Review Results** Fifteen (15) of 15 were compliant. **Appeal File Review Results** Ten (10) of 10 were 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;	Policy for Notice of Action Notice of Action Includes Member Grievance File and Member Appeal File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Resolution: Notice of Appeal Resolution section and the Initial Adverse Determination Notice policy. **Grievance File Review Results** Fifteen (15) of 15 were compliant.	

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
					Appeal File Review Results Ten (10) of 10 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;	Policy for Notice of Action Notice of Action Includes Member Appeals File Review			This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template. **Appeal File Review Results** Ten (10) of 10 files were compliant.	
13.5.2.3	The member's right to file an appeal with the MCO;	Policy for Notice of Action Notice of Action		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template.	
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	Policy for Notice of Action Notice of Action Includes Member Grievance File Review		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template. **Appeal File Review Results** Four (4) of 4 files were compliant. Six (6) of 6 were NA as the appeal was upheld in the member's favor.	
13.5.2.5	The procedures for exercising the rights specified in this section;	Policy for Notice of Action Notice of Action		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template.	
13.5.2.6	The circumstances under which expedited appeal is available and how to request it;	Policy for Notice of Action Notice of Action		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template.	
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	Policy for Notice of Action Notice of Action Includes Member Appeals File Review		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template. **Appeal File Review Results** Four (4) of 4 files were compliant. Six (6) of 6 were NA as the appeal was upheld in the member's favor.	

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
13.5.2.8	Availability of interpretation services for all languages and how to access them.	Policy for Notice of Action Notice of Action		Full	This requirement is addressed in the Initial Adverse Determination Notice policy and the Notice of Action template.	
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,:	Policy for Notice of Action			This requirement is addressed in the Initial Review Timeframes policy.	
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;	Policy for Notice of Action Includes Member Grievance File Review		Full	This requirement is addressed in the Initial Review Timeframes policy.	
13.5.3.3	By the date of action for the following: • In the death of a recipient; • 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 for Notice of Action		Full	This requirement is addressed in the Initial Review Timeframes policy.	
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.	Policy for Notice of Action		Full	This requirement is addressed in the Initial Review Timeframes 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
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.	Policy for Notice of Action Policy for Notice of Action for Standard Service Authorizations Policy for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Initial Review Timeframes policy.	
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; • 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.	Policy for Notice of Action Policy for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeal File Review		Full	This requirement is addressed in the Initial Review Timeframes policy. **Appeal File Review Results** There were no extended appeals in the sample files.	
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.	Policy for Notice of Action		Full	This requirement is addressed in the Initial Review Timeframes policy.	
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	Policy for Notice of Action Policy for Notice of Action for Expedited Service Authorizations		Full	This requirement is addressed in the Initial Review Timeframes 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
	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.					
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.	Policy for Notice of Action Policy for Handling Extensions Notice of Decision to Extend Timeframe		Full	This requirement is addressed in the Initial Review Timeframes policy.	
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 as the member's health condition requires, within the timeframes established below.	Policy for Grievances Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Standard Resolution section.	
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.	Policy for Grievances Includes Member Grievance File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Standard Resolution section. **<u>Grievance File Review Results</u>** Fifteen (15) of 15 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.	Policy for Appeals Includes Member Appeals file review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Standard Resolution section. **<u>Appeal File Review Results</u>** Ten (10) of 10 were compliant.	
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	Policy for Appeals Includes Member Appeals file review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Expedited Resolution section.	

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 appeal. This timeframe may be extended under Section 13.6.2 of this Section.				**Appeal File Review Results** Eight (8) of 8 were compliant. Two (2) of 2 were NA as not expedited appeals.	
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	Policy for Appeals Policy for Grievances Policy for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeals file review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Extension of Resolution section. **Appeal File Review Results** There were no extended appeals in the sample files.	
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.	Policy for Appeals Policy for Grievances Policy for Handling Extensions Notice of Decision to Extend Timeframe Includes Appeals File review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Extension of Resolution section. **Appeal File Review Results** There were no extended appeals in the sample files.	
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.	Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Failure to Make a Timely Appeal Decision section.	
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	Policy for Grievances Policy for Appeals Resolution Notice		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Resolution Letter sections and the Grievance Resolution template.	

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
	written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.					
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.	Policy for Appeals Resolution Notice		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Notice of Appeal Resolution sections and the Uphold and Overturn Resolution template.	
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.	Policy for Appeals Policy for Fair Hearings		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Timely Filing section under State Fair Hearing and the Grievance and Appeal section of the Member Handbook.	
13.6.6.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	Policy for Fair Hearings		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Parties to the State Fair Hearings section and the Grievance and Appeal section of the Member Handbook	
13.7	**Expedited Resolution of Appeals**					
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates	Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Expedited Resolution section.	

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
	(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.					
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.	Policy for Appeals Provider Handbook		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Punitive or Retaliatory Action section. This is also addressed in the Provider Manual.	
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.	Policy for Appeals Denial Notice		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Expedited Resolution Time section	
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.	Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Failure to Make a Timely Appeal Decision section	
13.7.4	**Process**	Policy for Appeals		Full	This requirement is addressed in the	

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
13.7.4.1	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.				Member Appeal, State Fair Hearing and Grievance Policy in the Appeal Process Requirements section	
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 Appeal, State Fair Hearing and Grievance Policy in the Evidence section	
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.	Policy for Appeals		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy.	
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must also make reasonable effort to provide oral notice.	Policy for Appeals Includes Member Appeal File Review		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy. **<u>Appeal File Review Results</u>** Eight (8) of 8 were compliant. Two (2) of 2 were NA as not expedited appeals	
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	Policy for Continuation of Benefits Process for notifying member of continuation of		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Continuation of Benefits section.	

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
	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.	benefits				
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.	Policy for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Continuation of Benefits section.	
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).	Policy for Continuation of Benefits Process for notifying member of continuation of benefits		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Recovering Costs section. This is also addressed in the Member Handbook in the Grievance and Appeals section.	
13.9	**Information to Providers and Contractors**					

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
13.9.0	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.	
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.	Policy for Grievances Policy for reporting grievances and resolutions to DHH Report Format		Full	This requirement was addressed through the submission of Report examples. Reports are submitted according to LDH regulatory schedule.	
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		Full	This requirement is addressed in the Member Appeal, State Fair Hearing and Grievance Policy in the Effectuation sections.	
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 Appeal, State Fair Hearing and Grievance Policy in the Effectuation sections.	

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 QM01_2019 CS_QIPD_LA_FINAL_EQRO Program Description on page 1, in QM01_UHC_2019CSQI Work Plan LA - February - EQRO Audit, and in QM01_2018_CS_QI_Eval_LA_Final_EQRO.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO QM01_UHC_2019CSQI Work Plan LA - February - EQRO Audit, QM01_2018_CS_QI_Eval_LA_Final_EQRO, the QM02_Medical Record Review Policy, and the QM02_Medical Record Executive Summaries 2018.	
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the QM01_UHC_2019CSQI Work Plan LA - February - EQRO Audit and in QM01_2018_CS_QI_Eval_LA_Final_EQRO.	
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	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the QM01_2018-2019 Population Health Strategy EQRO Audit on page 7, and in the ADHD Interim PIP Report.	

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
	a procedure, to the strategy.					
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 Prematurity Final PIP and in the ADHD Interim PIP, as well as in the QM-3_UHC_LA UM Strategic Plan 2019 EQRO Audit document, page 6.	
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 Interim PIP.	
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 broadly in the UM08_2019 UM Program Description signed Final 2_2019, the QM01_2018 CS QI Eval LA Final EQRO for special needs of members in the Dual Special Needs Program on page 5, and members with severe and persistent mental illness on page 18, and in the ADHD Interim PIP on page 40, with supporting documentation in the 14.1.9_Care Management Delegation Flow Chart.	
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 QM08_LHIN-ENSPresentation and the QM08_LHIN-ENSEmail.	
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	QAPI Program Description QAPI Work Plan		Full	The requirement is addressed in the QM01_2019 CS_QIPD_LA_FINAL_EQRO and the QM07_LA_CS_plan_Health_Disparities_Action_Plan.	

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
	accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of 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 QM01_LA QI5 Continuity and Coordination of Care Report 2018 EQRO Audit document and in the QM01_2018_CS_QI_Eval_LA_Final_EQRO document on page 19.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO and in the QM01_2018_CS_QI_Eval_LA_Final_EQRO, the ADHD Interim PIP, and the Prematurity Final PIP.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO on page 10, and in the QM12_BoardApprovalCertificate.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO on pages 11-14, the QM42_UHC_LA_MemberAdivsoryCouncil_3 QTR2018, and in the QM42_UHC_LA_ProviderAdivsoryCommittee _1QTR2019.	
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 QM14_SubmissionScreenshot, in the ADHD Interim PIP, the Prematurity Final PIP, and in the	

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
					QM14_LDHCollaborativePIPMeetingNotes_122018.	
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Clinical guidelines for ADHD Provider education Provider manual		Full	This requirement is addressed in the QM01_2018_CS_QI_Eval_LA_Final_EQRO on page 19.	
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 07_ProvNtwork_UHC_LA_EQRO_2019_2017 LA Provider Manual on page 70, and in QM01_2018_CS_QI_Eval_LA_Final_EQRO.	
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		Full	This requirement is addressed in the QM17_LDH_MedicaidQualityMeetingMinutes_11162018 and in the QM17_LDH_CollaborativePIPMeetingNotes_07192018.	
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 children receiving CSoC services and EBPs.	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH		Full	This requirement is addressed in the UHC_Report 355 Jan 2019.	
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	Outcome measures and results BH outcome measures and evidence shared with LDH		Full	This requirement is addressed in the UHC_Report 355 Jan 2019.	

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
	health services; the strategy will be due to LDH-OBH on an annual base.					
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 34_QMCMeetingMinutes_02142019.	
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee		Full	This requirement is addressed in the 34_QMCMeetingMinutes_02142019.	
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 34_QMCMeetingMinutes_02142019.	
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 LA-Member Advisory Plan Charter 12-20-17, the LA-Advisory-Council Minutes—2-2018 in English and Spanish, and the 2019 LA EQRO Narrative 14.2.14.	
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 34_QMCMeetingMinutes_02142019.	
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Program Description QAPI Work Plan QAPI Committee Description including roles and responsibilities		Full	This requirement is addressed in the QM01_2019_CS_AIPD_LA_FINAL_EQRO Program Description on page 11.	
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019_CS_AIPD_LA_FINAL_EQRO Program Description on page 11.	
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019_CS_AIPD_LA_FINAL_EQRO Program Description on page 11.	
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019_CS_AIPD_LA_FINAL_EQRO Program Description 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
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 QM01_2019_CS_AIPD_LA_FINAL_EQRO Program Description on page 11.	
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019_CS_QIPD_LA_FINAL_EQRO Program Description on page 26.	
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description		Full	The QM31_BlankPCOR Report addresses PCPs, the two sample LPC feedback letters, and corresponding TRR Def Rpt documents.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO Program Description on page 11, and in the QM01_2018_CS_QI_Eval_LA_Final_EQRO Evaluation Report, page 163.	
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019 CS_QIPD_LA_FINAL_EQRO Program Description on pages 12-13.	
14.2.2.9	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to LDH;	QAPI Program Description		Full	This requirement is addressed in the QM01_2019 CS_QIPD_LA_FINAL_EQRO Program Description on page 23, and in the QM34_PQ119_QAPI Committee Meeting Summary_1QRT2019.	
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 theQM01_2018_CS_QI_Eval_LA_Final_EQRO .	
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 QM17_LDH_MedicaidQualityMeetingMinutes_11162018 and in the QM17_LDH_MedicaidQualityMeetingMinutes_02152019.	
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 QM_Provider_Website_ERQO Audit 2019 and in the 2018 Provider Change Tracker.	
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement	QAPI Program Description QAPI Work Plan		Full	This requirement is addressed in the QM01_2019 CS_QIPD_LA_FINAL_EQRO on	

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
	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:	Evidence of timely submission of the written QAPI plan			pages 5 and 6, the QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, and in the QM38_SubmissionProof.	
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 is addressed in the QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, in the Objectives tab.	
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 QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, in the Activities tab.	
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 QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, in the Activities tab, the QM41_ClinicalPracticeConsultantJobDescription, and the QM41_ClinicalAdminCoordinatorJo Description.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QAPI Program Description		Full	This requirement is addressed in the QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, in the Activities tab	
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 QM01_UHC_2019CS QI Work Plan LA - February - EQRO Audit, in the Activities tab and the tabs for ADHD PIP, Prematurity PIP, and IET PIP.	
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		Full	This requirement is addressed in the QM01_2019 CS_QIPD_LA_FINAL_EQRO, in the QM01_2018_CS_QI_Eval_LA_Final_EQRO, the Evaluation Tools slide of the 14.2.3.6 EQRO Data document, and in the ADHD Interim PIP, the Prematurity Final PIP, and	

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
					the HEDIS 2018 Attestation document.	
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 UHC_BH EBP 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 QM01_2019 CS_QIPD_LA_FINAL_EQRO, the QM01_2018_CS_QI_Eval_LA_Final_EQRO, and the QM14_SubmissionScreenshot.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO on page 30, the QM01_2018_CS_QI_Eval_LA_Final_EQRO, page 127, and the QM07_Louisiana C&S Plan Health Disparities Action Plan on page 1.	
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 QM48_2018 IDSS art-11453, the QM65_2018_UHC_LA_AdultMedicaid_CAHPS_crosstabs, the QM65_2018_UHC_LA_ChildMedicaidwith CCC_CAHPS_GenPopCrosstabs, and the QM48_2018 Non HEDIS Submission reports.	
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 in the QM48_HEDIS Attestation-2018 and in the QM48_2018 Non HEDIS Submission Reports.	
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 QM48_2018 IDSS Art-11453, and the QM48_2018 Non HEDIS Submission Reports, in the Final Prematurity PIP.	

Quality Management						
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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 QM01_2019 CS_QIPD_LA_FINAL_EQRO on page 30.	
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 QM01_2019 CS_QIPD_LA_FINAL_EQRO on page 30, and in the QM48_NonHEDIS_Measures_Calendard2017_Revised 1018.	
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		Full	This requirement is addressed in the QM01_2018_CS_QI_Eval_LA_Final_EQRO on pages 62 and 111.	
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 QM48_2018 IDSS Workbook-11453 and in the QM48_NonHEDIS_Measures_Calendard2017_Revised 1018.	
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	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 QM48_NonHEDIS_Measures_Calendard2017_Revised 1018 and in the Prematurity PIP	

Quality Management						
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					Final 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 QM48_2018 IDSS Workbook-11453 and in the QM48_NonHEDIS_Measures_Calendard2017_Revised 1018.	
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 QM48_HEDIS Attestation-2018.	
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 IET PIP proposal, the ADHD Interim PIP Report, and the Final Prematurity PIP Report.	
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 IET PIP Proposal, the ADHD Interim PIP Report, and the Final Prematurity PIP Report.	
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 IET PIP Proposal and in the 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;	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the IET PIP Proposal, the ADHD Interim PIP Report, and the Final Prematurity PIP Report.	

Quality Management						
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	• 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.					
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: • 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.	PIP proposal/reports P/P performance input projects PIP meeting minutes		Full	This requirement is addressed in the IET PIP Proposal, the ADHD Interim PIP Report, and the Final Prematurity PIP Report.	
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall:	PIP proposal/reports P/P performance input projects		Full	This requirement is addressed in the IET PIP Proposal, the ADHD Interim PIP Report, and the Final Prematurity PIP Report.	

Quality Management						
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	• Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable 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	PIP meeting minutes				

Quality Management						
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	• 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 QM65_UHC_LA_CAHPS Executive Summary_2019 EQRO Audit, the QM65_2018_UHC_LA_Adult Medicad_CAHPS Crosstabs, and the QM65_2018_UHC_LA_Child Medicaid with CCC_CAHPS Gen Pop 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 Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	CAHPS Vendor contract		Full	This requirement is addressed in the QM65_UHC_LA_CAHPS Executive Summary_2019 EQRO Audit.	
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_UHC_LA_Adult Medicaid_CAHPS and 2018_UHC_LA_Child Medicaid with CCC_CAHPS Reports.	
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 CAHS 5.0H Member Survey Adult Medicaid prepared by DSS Research June 2018, in the QM65_2018_UHC_LA_Adult Medicaid_CAHPS Crosstabs, and the QM65_2018_UHC_LA_Child Medicaid with CCC_CAHPS Gen Pop 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 QM65_UHC_LA_CAHPS Executive Summary_2019 EQRO Audit, the QM65_2018_UHC_LA_Adult Medicad_CAHPS Crosstabs, and the QM65_2018_UHC_LA_Child Medicaid with CCC_CAHPS Gen Pop Crosstabs.	
14.2.10.7	Analyses shall provide statistical analysis for	CAHPS reports		Full	This requirement is addressed in the	

Quality Management						
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	targeting improvement efforts and comparison to national and state benchmark standards.				QM65_UHC_LA_CAHPS Executive Summary_2019 EQRO Audit and in the 2018_UHC_LA_Child Medicaid with CCC_CAHPS and 2018_UHC_LA_Audit Medicaid_CAHPS reports.	
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 QM65_UHC_LA_CAHPS Executive Summary_2019 EQRO Audit.	
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 LDH on an annual basis.	P/P Behavioral health survey Timeline for BH survey administration BH survey results, if administered		Full	This requirement is addressed in the Final Report 351 for State Submission 6.6.2018.	
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 QM73_UHC_LA_NCQA_Commendable Report, the QM73_UHC_LA_AccreditationSummary_08302018, and the QM73-UHC_LA_AccreditationScore_08302018.	
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 QM73_UHC_LA_AccreditationAwardLetter_07102017.	
14.4.3	The MCO shall provide LDH with a copy of its most	Accreditation Status		Full	This requirement is addressed in the	

Quality Management						
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	recent accreditation review including:	including copy of accreditation report if accredited			QM73_UHC_LA_AccreditationSummary_083 02018.	
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 QM73_UHC_LA_NCQA_Commendable Report and the QM73_UHC_LA_AccreditationSummary_083 02018.	
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 QM73_UHC_LA_AccreditationSummary_083 02018.	
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 QM73_UHC_LA_NCQA_Commendable Report.	
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	Accreditation Status including copy of accreditation report if accredited		Full	This requirement is addressed in the QM73_UHC_LA_NCQA_Commendable Report.	
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 QM80_Member Advisory Plan Council Charter 12-19-2014, the QM80_Member Advisory Council Plan Website, and the QM80_Member Advisory Council Agenda and Minutes Q2 20118.	
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 QM80_Member Advisory Council Plan Website, and the QM80_Member Advisory Council Agenda and Minutes Q2 20118.	

Quality Management						
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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 QM80_Member Advisory Council Plan Website and the QM80_Member Advisory Council Agenda and Minutes Q2 2018.	
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 QM80_Member Advisory Plan Council Charter 12-19-2014, in the Member Advisory Council Orientation section. The MCE explained that no attendance sheets were available during the review period because there were no new members, so no training was conducted during the review period.	
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan		Full	This requirement is addressed in the 141 UHC 2018 UHC Member Advisory Council Plan.pdf, as well as the QM80_Member Advisory Council Plan Website and the Member Advisory Council – Meeting Communication.	
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 LA – Member Advisory Plan Charter 12-20-17 on page 5, the LA-Advisory-Council-Minutes-Q2-2018-ENGLISH, and the LA-Advisory-Council-Minutes-Q2-2018-SPANISH.	
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	Fidelity monitoring plan MOUs Evidence of submission to LDH		Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019, the LA Medicaid_Healthy LA Prvdr site_DesktopAudits.pdf Policy and Procedure, the 13- LA Behavioral Health	

Quality Management						
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	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.				Monitoring Audits Workflow, and the UHCCP-LA SUD Treatment Record Tool 2019. No audits have been completed yet as the tools were recently approved. The plan will meet to determine how to incorporate reporting into PIP Quarterly ITM Reporting.	
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 Monitoring tool.	Fidelity monitoring plan Evidence of submission to LDH		Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019 and the Evidence-Based Practices Kit for Assertive Community Treatment: Evaluating Your Program; however, documentation of staff training was not provided, and the MCE rationale was that this training is contracted out to Case Western Reserve University. On-site, the MCE explained that the MCE receives reports from Case Western and uses those to conduct outreach for quality improvement and/or corrective action plans as indicated, and provided the Assertive Community Treatment General Organizational Index Volunteers of America VoA Lafayette_12_13_18.pdf report, with scoring.	
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,	Fidelity monitoring plan Site visit reports Evidence of submission to LDH		Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019, and in the Heatlhy Louisiana EBP Report: UHC_Report 355 Jan 2019.	

Quality Management						
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	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.					
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 QM89_326_AdverseIncidentReport_March2019, the QM89_326_LA_Healthly_Adverse_Incident Report_Cover, the Letter_03012019 QM89_ProofofSubmission, and the QM89_LA_CS_352_AdverseIncidentReportingPolicy.	
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 quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	P/P BH reporting		Full	This requirement is addressed in the QM89_326_AdverseIncidentReport_March2019, the QM89_326_LA_Healthly_Adverse_Incident Report_Cover, the Letter_03012019 QM89_ProofofSubmission, and the	

Quality Management						
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					QM89_LA_CS_352_AdverseIncidentReportingPolicy.	
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 UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
14.9.1.1	Review criteria for each applicable provider type/level of care;			Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
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 UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
14.9.1.3	Member interview criteria;			Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019.	
14.9.1.4	Random audit selection criteria;			Full	This requirement is addressed in the LA BH Monitoring Audits Workflow Guidelines.	
14.9.1.5	Tools to be used;			Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019.	
14.9.1.6	Frequency of review, including schedule of reviews by provider type;			Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
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 UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
14.9.1.8	Plan for ensuring corrective actions are			Full	This requirement is addressed in the LA BH	

Quality Management						
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	implemented appropriately and timely by providers; and				Monitoring Audits Workflow Guidelines.	
14.9.1.9	Inter-rater reliability testing methods.			Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019.	
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. Additional levels of care may be added at the discretion of LDH.	P/P BH reporting		Full	This requirement is addressed in the LA BH Monitoring Audits Workflow Guidelines.	
14.9.3	The MCO's review criteria shall address the following areas at a minimum:	P/P BH reporting				
14.9.3.1	Adherence to clinical practice guidelines;			Full	This requirement is addressed in the LA Medicaid Healthy LA Provider Site Desktop Audits Policy and Procedure.	
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;			Full	This requirement is addressed in the UHCCP-LA SUD Treatment Record Tool 2019 and in the UHCCP_LA Treatment Record Tool March2019.	
14.9.3.3	Cultural competency;			Full	This requirement is addressed in the UHCCP-LA SUD Treatment Record Tool 2019 and in the UHCCP_LA Treatment Record Tool March2019.	
14.9.3.4	Patient safety;			Full	This requirement is addressed in the UHCCP-LA SUD Treatment Record Tool 2019 and in the UHCCP_LA Treatment Record Tool March2019.	
14.9.3.5	Compliance with adverse incident reporting requirements;			Full	This requirement is addressed in the QM89_329_AdverseIncidentReport_March2019 and in the QM89_LA_CS_352_AdverseIncidentReportingPolicy.	

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
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;			Full	This requirement is addressed in the QM89_329_AdverseIncidentReport_March2019.	
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 UHCCP-LA SUD Treatment Record Tool 2019 and in the UHCCP_LA Treatment Record Tool March2019.	
14.9.3.8	Continuity and coordination of care, including adequate discharge planning			Full	This requirement is addressed in the UHCCP-LA SUD Treatment Record Tool 2019 and in the UHCCP_LA Treatment Record Tool March2019.	
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently					

Quality Management						
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	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 UHC_BH EBP Fidelity Monitoring Plan 2019 and the LA BH Monitoring Audits Workflow Guidelines.	
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 UHC_Report 355 Jan 2019.	
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 UHC_BH EBP Fidelity Monitoring Plan 2019 and the UHC_Report 355 Jan 2019.	
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 UHC_BH EBP Fidelity Monitoring Plan 2019, the Evidence-Based Practices Kit for Assertive Community Treatment: Evaluating Your Program, the LA Medicaid Provider Site and Desktop Audits Policy and Procedure, and in the 13-LA Behavioral Health Monitoring Audits Workflow. In addition, the training schedule and status of training completed was provided for the one new staff member that was trained during the review period.	
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and	BH outcome assessment plan		Full	This requirement is addressed in the UHC_BH EBP Fidelity Monitoring Plan 2019	

Quality Management						
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	reporting to the LDH.				and the UHC_Report 355 Jan 2019.	

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 FWA Compliance Plan and the COC Minutes.	
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		Full	This requirement is addressed in the FWA Compliance Plan.	

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.					
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 in the FWA Compliance 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		Full	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	proceedings, pre-trial conferences, hearings, trials, and in any other process.					
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 is not addressed in the FWA plan but is addressed by the recordkeeping section of the Community and State Appeals policy. The MCO provided their Grievance and Appeals Reports (112 and 113 Reports). **Recommendation** The MCO should include this language in the FWA Compliance Plan.	This language was added to the FWA Compliance Plan and submitted to LDH in August 2019.
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		Full	This requirement is addressed in the FWA plan.	
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		Full	This requirement is addressed in the FWA plan.	
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	This requirement is addressed in the FWA plan and evidenced by the Provider Entity Disclosure Form.	

Fraud, Abuse, and Waste Prevention						
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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		Full	This requirement is addressed in the FWA plan, disclosure forms and evidenced by the Report 170 submission confirmation to the state.	
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 in the FWA Compliance 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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	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 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 partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH.	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.
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		Full	This requirement is partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH. **Final Review Determination** The review determination was changed to Full. Based on the response provided by UHC, we found this information in the SOP Prohibition to Recoup or Withhold document.	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan		Full	This requirement is partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments.	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA

Fraud, Abuse, and Waste Prevention						
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					Recommendation The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH. **Final Review Determination** The review determination was changed to Full. Based on the response provided by UHC, we found this information in the SOP Prohibition to Recoup or Withhold document.	presite deliverables.
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		Full	This requirement is partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH. **Final Review Determination** The review determination was changed to Full. Based on the response provided by UHC, we found this information in the SOP Prohibition to Recoup or Withhold document.	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.
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		Full	This requirement is partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are	The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.

Fraud, Abuse, and Waste Prevention						
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					prohibited when directed by LDH. **<u>Final Review Determination</u>** The review determination was changed to Full. Based on the response provided by UHC, we found this information in the SOP Prohibition to Recoup or Withhold document.	
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 Policy		Full	This requirement is addressed in the FWA Compliance Plan.	
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 FWA Compliance Plan and the 145 Reports.	
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 LDH when the concerns and/or allegations of any	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan, and as discussed onsite, annual employee training is conducted. Substantiation of Tips was discussed onsite. The MCO submits the 145 – FWA Activity report regularly to LDH.	

Fraud, Abuse, and Waste Prevention						
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	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 in the FWA Compliance Plan. 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 in the FWA Compliance Plan. The MCO submits the 145 – FWA Activity report regularly to LDH.	
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 in the FWA Compliance Plan. The MCO submits the 145 – FWA Activity report regularly to LDH.	
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 in the FWA Compliance Plan. The MCO submits the 145 – FWA Activity report regularly to 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		Full	This requirement is addressed in the FWA Compliance Plan. The MCO submits the 145 – FWA Activity report regularly to 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 Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form	FWA Compliance Plan Provider referral forms		Full	This requirement is addressed in the FWA Compliance Plan and a sample provider Fraud Referral form. The MCO submits the 145 – FWA Activity report regularly to 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,	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

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
	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:					
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	
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		Full	This requirement is addressed in the FWA Compliance Plan.	
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 in the FWA Compliance Plan.	
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 administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	
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.			Full	This requirement is addressed in the FWA Compliance Plan and by the Provider Suspension Payment policy.	

Fraud, Abuse, and Waste Prevention						
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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 partially addressed by the BH Provider Contracts. **Recommendation** The MCO should include this requirement language in the FWA Compliance Plan. **Final Review Determination** The review determination was changed to Full. Based on the response provided by UHC, we find the language in section 4.7 of the Louisiana Medicaid and CHIP Program Appendix for Medical Subcontractors addresses this requirement.	We believe this requirement is encompassed in the more comprehensive criteria from the Louisiana Medicaid Regulatory Appendix Section 4.7 submitted as part of this audit. Nevertheless, it was added to the FWA Compliance Plan and submitted to LDH in August 2019. 4.7 Compliance with Laws, State Contract and LDH-Issued Guides. Subcontractor shall, and shall require Provider to comply with all requirements for Health Plan subcontractors set forth in the State Contract and LDH-issued guides, as well as with all applicable federal and State laws, rules, regulations and guidelines applicable to the provision of services under the State Program. The State Contract and LDH-issued guides shall be furnished to Subcontractor and Provider upon request. Subcontractor and Provider

Fraud, Abuse, and Waste Prevention						
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						may also access these documents on the LDH website at http://www.makingmedicaidbetter.com. United also shall furnish Subcontractor and Provider (either directly or through a web portal) with United's provider manual and member handbook.
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	This requirement is addressed in the FWA Compliance Plan.	
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 requirement is addressed in the FWA Compliance Plan.	
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	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	waste in the administration and delivery of services.					
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the 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. .	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan, and staff were able to discuss the structure of the Program Integrity structure and coordination with Optum for reporting and investigative staff.	
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	This requirement is addressed in the FWA Compliance Plan, and staff were able to discuss the structure of the Program Integrity structure and coordination with Optum for reporting and investigative staff.	
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	This requirement is addressed in the FWA Compliance Plan, and staff were able to discuss the structure of the Program Integrity structure and coordination with Optum for reporting and investigative staff.	
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	This requirement is addressed in the Compliance Committee Charter and COC quarterly minutes.	

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
15.2.6	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 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:	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	
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 FWA Compliance 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 FWA Compliance Plan.	
15.2.6.3	Enforcement through well-publicized disciplinary guidelines;			Full	This requirement is addressed in the FWA Compliance 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 FWA Compliance 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 FWA Compliance Plan.	
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	This requirement is addressed in the FWA Compliance Plan.	
15.2.6.7	Written policies and procedures for conducting			Full	This requirement is addressed in the FWA	

Fraud, Abuse, and Waste Prevention						
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	both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.				Compliance Plan and Onsite SIU Visit Policy.	
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.			Full	This requirement is addressed in the FWA Compliance 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 in the FWA Compliance Plan.	
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 FWA Compliance Plan.	
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 FWA Compliance 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 FWA Compliance Plan.	
15.2.6.13	Fraud, Waste and Abuse Training shall include, but			Full	This requirement is addressed in the FWA	

Fraud, Abuse, and Waste Prevention						
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	not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.				Compliance Plan.	
15.2.6.14	The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse 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.			Full	This requirement is addressed in the FWA Compliance Plan.	
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)	Overpayments Policy Overpayments notice form		Full	This requirement is addressed in the FWA Compliance Plan and Overpayment Refund Forms.	

Fraud, Abuse, and Waste Prevention						
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	calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.					
	The MCO shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.	Overpayments Policy		Full	This requirement is addressed in the FWA Compliance Plan.	
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	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	(SAM); and • Other applicable sites as may be determined by LDH					
15.3.6	The MCO and its subcontractors shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to 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).	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	the provision of items and services which are significant and material to the MCO's obligations under this contract. • A network provider.					
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	This requirement is addressed in the FWA Compliance Plan.	
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	This requirement is addressed in the 148 Report Attestation Confirmation email.	
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 in the FWA Compliance Plan.	
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	This requirement is addressed in the FWA Compliance Plan.	
15.5						
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		Full	This requirement is addressed in the FWA Compliance Plan.	
15.5.2	The MCO shall notify LDH within three (3) business days of the time it receives notice that action is	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

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
	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.					
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 in 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 in 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 in 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 in the 145 Report.	
15.5.4	The MCO shall report to LDH Program Integrity at least quarterly all audits performed and	FWA Compliance Plan Copies of quarterly reports		Full	This requirement is addressed in the 145 Report.	

Fraud, Abuse, and Waste Prevention						
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	overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)] .					
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 in 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						
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:	Policy for medical records Policy for medical record documentation standards Policy for medical record monitoring Provider Manual Model Provider Contracts for all provider types		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.1.1	Accurate and legible;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records 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	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.1	Member identifying information, including name,	Policy for medical records		Full	This requirement is addressed in the	

Fraud, Abuse, and Waste Prevention						
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	identification number, date of birth, sex and legal guardianship (if applicable);	Policy for medical record standards			Provider Manual and the Medical Records Review Policy.	
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records 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;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.5	Referrals including follow-up and outcome of referrals;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.7	Signed and dated consent forms (as applicable);	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.8	Documentation of immunization status;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	
15.6.2.9	Documentation of advance directives, as appropriate;	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records 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); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records Review Policy.	

Fraud, Abuse, and Waste Prevention						
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	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.	Policy for medical records Policy for medical record standards		Full	This requirement is addressed in the Provider Manual and the Medical Records 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.	Policy for medical records		Full	This requirement is addressed in the Provider Manual and the Medical Records 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.	Policy for medical records Policy for medical record retention		Full	This requirement is addressed in the Provider Manual.	
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 addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan and the 145 Reports.	

Fraud, Abuse, and Waste Prevention						
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	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.					
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		Full	This requirement is addressed in the FWA Compliance Plan.	
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		Full	This requirement is addressed in the FWA Compliance Plan.	
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		Full	This requirement is addressed in the FWA Compliance Plan.	
15.7.6	If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of					

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 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		Full	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	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.					
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		Full	This requirement is addressed in the FWA Compliance Plan.	
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 addressed in the FWA Compliance Plan and the Right of Recovery Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the Right of Recovery Plan.	

Fraud, Abuse, and Waste Prevention						
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	by the MCO and/or Department until resolved or dismissed under Department rules.					
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.					
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 LA MGA Drafting Tools.	
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		Full	This requirement is addressed in the Right of Recovery Plan.	
	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:	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	https://oig.hhs.gov/exclusions/index.asp.					
4.1.4	The MCO shall comply with LDH Policy 8133-98, "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.	FWA Compliance Plan		Full	This requirement is addressed in the Employee Background Checks Policy.	
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	This requirement is addressed in the FWA Compliance Plan.	
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 in the FWA Compliance Plan.	
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from	FWA Compliance Plan Provider Enrollment and		Full	This requirement is addressed in the FWA Compliance Plan.	

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	participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	Contract Forms				
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		Full	This requirement is addressed in the FWA Compliance Plan.	
17.2.6.1.9	**Provider Validation–** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	FWA Compliance Plan		Full	This requirement is addressed in the Provider Sanctions Monitoring Policy.	
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	FWA Compliance Plan Report 170 Ownership Disclosure		Full	This requirement is addressed in the 170 Report Submission Confirmation.	

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	(35) days when any change in the MCO's management, ownership or control occurs.					
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, "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.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	An organizational Conflicts of Interest Training document was provided, and the requirement is addressed in the Annual FWA Compliance Program.	

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	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.					
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 Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	FWA Compliance Plan Provider Enrollment and Contract Forms		Full	This requirement is addressed in the FWA Compliance Plan.	
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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

Fraud, Abuse, and Waste Prevention						
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	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 .					
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 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	FWA Compliance Plan		Full	This requirement is addressed in the FWA Compliance Plan.	

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	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 be 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	UHC provided a screen shot of Orbit sample reports. In addition screen shots of the Facets claims/eligibility system were provided. Majority of reports are provided by the Reporting Team. Local UHC team updates to meet LDH requirements. Reports due 15th of the month. No issues with timeliness per UHC.	