Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.0	**Provider Network**			
6.0.1	The CCN must provide a comprehensive primary care network to ensure its membership has access at least equal to, or better than community norms.	Full	Addressed in PS 08.08 Network Development & Management, and in the 2013 Provider Network Development & Management Plan.	
6.0.2	Services shall be accessible to CCN members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients within the same GSA who are not enrolled in the CCN Program.	Full	Addressed in CHS-LA Provider Subcontract, v 15, dated 6/3/13.	
6.0.3	The CCN is encouraged to have available non-emergent after-hours physician or primary care services within its network.	Full	Addressed in PS 08.08.Providers are incentivized to provide extended hours.	
6.0.4	If the network is unable to provide medically necessary services required under Contract, the CCN shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted.	Full	Addressed in 2013 Provider Network Development & Management Plan.	
6.0.5	The CCN is responsible for covering services related to the following: the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to	Full	Addressed in CHS-LA Provider Subcontract, v 15, dated 6/3/13 and the Provider Handbook.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	attain, maintain, or regain functional capacity.			
6.0.6	The CCN is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the CCN's member population.	Substantial	Provider location report for Q4 shows distribution of 2,583 providers at 668 locations within 20 and 30 mile radius. Q3 geocoded map shows adult member locations and adult provider locations. Geo-mapping for child members was not provided.	MCO response: Completed: Quarterly Reporting. Provider Services will include pediatric geo-mapping on a quarterly basis, in addition to existing adult members reporting. IPRO response: Determination unchanged. Geo-mapping will be reviewed as part of next year's audit.
6.0.7	There shall be sufficient personnel for the provision of all enhanced primary care case management services.	Full	Network adequacy report for 9/30/12 showing executed PCP contracts per GSA and statewide by provider specialty provided A reduction in the number of OB/GYN providers was noted; from 21 to 12. This reduction was discussed with CHS. It was reported that OB/GYN providers acted as primary during pregnancy but were not willing to remain primary after delivery. CHS was not able to engage additional OB/GYN providers however the plan reports no difficulty with arranging linkages to OB/GYN providers.	
6.1	**Significant Traditional Providers**			
6.1.1	The CCN shall make a good faith effort to include in its network significant traditional providers (STPs) in its GSA for the first two (2) years of operation under the CCN Contract; provided the STP agrees to participate as an in-network provider and abide by the provisions of the provider subcontract with the CCN.	Full	Addressed in PS 08.08.	
6.1.2	In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall	Full	Addressed in PS 08.08.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	maintain documentation detailing efforts which were made.			
6.1.3	This requirement does not prohibit the CCN from limiting provider participation to the extent necessary to meet the needs of the CCN members. This requirement does not interfere with measures established by the CCN to control costs and quality consistent with its responsibilities under this contract.	Full	Addressed in PS 08.08.	
6.2	**Network Provider Development and Management Plan**			
6.2.0.1	The CCN shall develop and maintain a Primary Care Network Provider Development and Management Plan which ensures access to primary care services and PCP case management services.	Full	Addressed in 2013 Provider Network Development & Management Plan.	
6.2.0.2	The Network Development and Management Plan shall be evaluated, updated annually and submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the CCN and annually thereafter. The submission of the Network Management and Development Plan to DHH is an assurance of the adequacy and sufficiency of the CCN's primary care provider network.	Full	Addressed in 2013 Provider Network Development & Management Plan and PS 08.08.	
6.2.0.3	The CCN shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services.	Full	Addressed in 2013 Provider Network Development & Management Plan. Per the Plan, ad-hoc geo-coding will occur within 3 business days of notification of loss of a significant provider. Members are notified of changes in the provider network 30 days prior to the change	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			taking place.	
6.2.0.4	In accordance with the requirements in this RFP, and the members' needs, the proposed network shall be sufficient to provide core benefits and services within designated time and distance limits. The Network Provider Development and Management Plan shall identify gaps in the CCN's provider network and describe the process by which the CCN shall assure all covered services are delivered to CCN members. Planned interventions to be taken to resolve such gaps shall also be included.	Full	Addressed in 2013 Provider Network Development & Management Plan.	
6.2.0.5	The CCN must maintain and monitor a primary care provider network that is supported by written agreements and is sufficient to meet the minimum capacity requirements set forth in this RFP. When designing this network, the CCN must take into consideration all the requirements specified in this RFP's terms and conditions. This includes access standards and guidelines for delivery of primary care services.	Full	CHS provided the Provider Contract and application. Also addressed in the Provider Network Development & Management Plan.	
6.2.1	The CCN shall provide GEO mapping and coding of all PCPs by provider type by the deadline date specified in the Schedule of Events to geographically demonstrate capacity. The CCN shall provide updated GEO coding to DHH	Substantial	Geo-mapping provided does not show mapping of PCPs by provider type, only in aggregate.	MCO response: Completed. PS 08.08 Network Development and Management policy and procedure revised to include quarterly geo-mapping depicting PCPs by provider type per GSA. IPRO response:

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	quarterly, or upon material change or upon request.			Determination unchanged. Geo-mapping will be reviewed as part of next year's audit.
6.2.2	The CCN shall develop and implement Network Development and Management policies and policies detailing how the CCN will:	N/A		
6.2.2.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Full	Addressed in 2013 Provider Network Development & Management Plan. CHS communicates with providers via various methods including: posting updates on the website, provider newsletters, quarterly onsite Provider Services Representative meetings, FAX cover sheets, e-blasts and FAX blasts, and communications through provider associations.	
6.2.2.2	Monitor network compliance with policies and rules of DHH and the CCN, 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;	Full	Addressed in 2013 Provider Network Development & Management Plan.	
6.2.2.3	Evaluate the quality of services delivered by the network;	Full	Addressed in 2013 Provider Network Development & Management Plan. Per the Plan, all quality of care concerns are reviewed by the Physician Review Committee and reported to the Quality Management Committee. Peer to peer interventions or education also conducted. Monthly reports and a Physician Dashboard are provided to providers.	
6.2.2.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Full	Addressed in PS 08.08.02.	
6.2.2.5	Monitor the adequacy, accessibility and availability of its PCP network	Substantial	Addressed in 2013 Provider Network Development & Management Plan. Per Plan, CHS conducts geocoding	MCO response: Completed: Quarterly Reporting.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to meet the needs of its members, including the provision of care to members with limited proficiency in English; and		of practices indicating proficiency in predominant languages in the parish. Geocoding demonstrating monitoring was not provided.	Provider Services will pull reports on a quarterly basis. Network Provider Services Manager will monitor reports on a quarterly basis to ensure adequacy, accessibility, and availability of PCP network to meet member needs. IPRO response: Determination unchanged. Geo-mapping process and reports will be reviewed as part of next year's audit.
6.2.2.6	Contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling;	Full	Addressed in CHS-LA Provider Subcontract.	
6.2.2.7	Provide training for its PCPs and maintain records of such training;	Full	Provider orientation registration form and instructions provided. Per the evaluation of the 2012 Provider Development & Management Plan, CHS provided training in group settings during 2011/2012 due to the volume of newly contracted providers. When requested, training was provided for individual offices and hospital systems. Orientation materials are also available to providers on the CHS website.	
6.2.2.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Full	Per the Provider Development & Management Plan, provider complaints are evaluated annually. For 2012 the majority of complaints related to processing of claims. As a result CHS requested weekly meetings with DHH and Molina to investigate/resolve claim-related complaints. Per CHS, these meetings have been very helpful resulting in quicker resolution.	
6.2.2.9	Ensure that provider calls 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	Full	Addressed in PS 08.04.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	DHH). If not resolved in 30 days the CCN must document why the issue goes unresolved; however, the issue must be resolved within 90 days.			
6.2.3	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Full	The 2013 Provider Network Development & Management Plan included the evaluation of the 2012 Plan. Two areas of improvement and one area of strength were identified. Area of strength: methods used in contracting providers such as face-to-face visits with practices; and willingness to educate providers. Areas of improvement: provider training and ongoing provider communication. CHS took the following actions: tracking and f/u of provider compliance with training; expansion of communication methods to include messaging through provider associations, FAX coversheets, FAX blasts and e-blasts.	
6.2.4	CCN Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	N/A		
6.3	**Manner of Service Delivery and Provision**			
6.3.0.1	In establishing and maintaining the PCP network, the CCN shall consider the following:	N/A		
6.3.0.2	The maximum Medicaid enrollment capacity;	Full	Addressed in IS 08.01.	
6.3.0.3	The expected utilization of services, taking into consideration the characteristics and health care	Full	Addressed in IS 08.01.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	needs of specific Medicaid populations enrolled in the CCN;			
6.3.0.4	The number of network providers who are not accepting new Medicaid patients; and	Full	Addressed in IS 08.01.	
6.3.0.5	The geographic location of providers and Medicaid members; considering distance travel time, and means of transportation ordinarily used by Medicaid members.	Full	Addressed in IS 08.01.	
6.3.0.6	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Full	Addressed in the Provider Contract.	
6.3.0.7	The CCN shall allow female members direct access to a women's health specialist for Louisiana Medicaid State Plan services necessary to provide women's routine and preventive health care services. This is in addition to the members designated source of primary care if that source is not a women's health specialist.	Full	Addressed in CM 08.01 Direct Access to Care, OB/GYN and Member Handbook.	
6.4	**Mainstreaming**			
6.4.1	DHH considers mainstreaming of CCN members into the broader health delivery system to be important. The CCN therefore must ensure that all CCN providers accept members for treatment and that	Full	Addressed in PS 08.08 and the Provider Handbook. Compliance is evaluated during quarterly PSR onsite visits and through monitoring of utilization trends.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN providers do not intentionally segregate members in any way from other persons receiving services.			
6.4.2	To ensure mainstreaming of members, the CCN shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following: Denying or not providing to a member any covered service or availability of a facility. 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. 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.	Full	Addressed in the Provider Handbook.	
6.4.3	If the CCN knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of	Full	Addressed in PS 08.08.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the subcontract are more restrictive than the Contract), DHH shall consider the CCN to have breached the provisions and requirements of the contract. In addition, if the CCN becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) calendar days, DHH shall consider the CCN to have breached the provisions and requirements of the Contract.			
6.5	**Primary Care Providers (PCP)**			
6.5.0.1	A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management which are found to be medically necessary, are made available in a timely manner as outlined in this RFP.	Full	Addressed in the Provider Handbook.	
6.5.0.4	The CCN shall identify and report to the Enrollment Broker within seven (7) calendar days any PCP approved to provide services described within this RFP who will not accept new patients or has reached capacity.	Full	Addressed in the Provider Network Development & Management Plan.	
6.5.0.5	The PCP shall serve as the member's initial and most important point of interaction.	Full	Addressed in the Provider Handbook.	
6.6	**PCP Responsibilities**			
6.6.1	The PCP responsibilities shall include, but not be limited to:	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.6.1.1	Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;	Full	Addressed in the Provider Subcontract.	
6.6.1.2	Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment;	Full	Addressed in the Provider Subcontract.	
6.6.1.3	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid;	Full	Addressed in the Provider Subcontract.	
6.6.1.4	Maintaining a medical record of all services rendered by the PCP and other referral providers.	Full	Addressed in the Provider Subcontract.	
6.6.1.5	Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions;	Full	Addressed in the Provider Subcontract.	
6.6.1.6	Providing case management services to include, but not be limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities as defined in the Contract;	Full	Addressed in the Provider Subcontract.	
6.6.1.7	Prohibiting discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	care services.			
6.6.2	Examples of Acceptable PCP After-Hours Coverage: the PCP's office telephone is answered after-hours by an answering service, can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes. The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable. The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.	Full	Addressed in the June 2013 Provider Newsletter and Provider Handbook.	
6.6.3	Examples of Unacceptable PCP After-Hours Coverage: the office telephone is only answered during office hours; the office telephone is answered after-hours by a recording that tells patients to leave a message; the office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and returning	Full	Addressed in the June 2013 Provider Newsletter and Provider Handbook.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	after-hours calls outside of 30 minutes.			
6.7	**Adequacy of Network Provider**			
6.7.1	The CCN shall maintain appropriate levels of primary care providers for the provision of services within the each GSA to insure that all required core benefits and services are available and accessible in a timely manner in accordance with this RFP. The CCN shall enter into contracts with a sufficient number of PCPs to ensure adequate accessibility and sustainability for members.	Full	Addressed in IS 08.01, PS 08.08 and PS 08.08.02.	
6.7.2	The locations of primary care providers must be sufficient in terms of geographic convenience to CCN members.	Full	Addressed in IS 08.01, PS 08.08 and PS 08.08.02.	
6.7.3	The CCN shall notify DHH immediately of any changes to the composition of its provider network that materially and/or adversely affects its ability to make available all primary care services and care management services in a timely manner in accordance with this RFP.	Full	Per the Provider Network Development & Management Plan, all changes will be conveyed to DHH within one business day.	
6.7.4	The CCN shall have procedures to address changes in its provider network that negatively affect the ability of CCN members to access services. Material changes in provider network composition that are not prior approved by DHH and/or that may impair the CCN member's access to services will be	Full	Addressed in the Provider Network Development & Management Plan.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	considered as grounds for sanctions, including but not limited to, termination of Contract. The CCN understands and agrees that notwithstanding the execution of this Contract, neither the CCN nor its contractor/network provider shall provide any services to a CCN member until the CCN has an adequate provider network verified and approved by DHH. Enrollees must receive written notice within thirty (30) days of any material change in provider network before the intended effective date of the change.			
6.7.7	The CCN shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers and provide verification to DHH. Failure to do so may result in monetary penalties up to $5,000 per day against the CCN.	Full	Addressed in the Provider Network Development & Management Plan.	
6.8	**Material Change to Provider Network**			
6.8.1	All material changes in the CCN's provider network must be approved in advance by DHH, BHSF/Medicaid Coordinated Care Section.	Substantial	Per PS 08.08, any material changes in the provider network shall be conveyed to DHH within one business day. The document does not specify approval in advance of changes that will be requested.	MCO response: Completed. PS 08.08 Network Development and Management policy and procedure revised to include that approval is needed in advance of changes that will be requested. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
6.8.2	A material change to the provider network is defined as one which	N/A	Definition	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	affects, or can reasonably be foreseen to affect, the CCN's ability to meet the performance and network standards as described in this Contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered.			
6.8.3	The CCN must submit the request for approval of a material change in their provider network, including copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Substantial	Per PS 08.08, material changes are conveyed to DHH within one business day. This document does not address request for approval or a draft notification to members.	MCO response: Completed. PS 08.08 Network Development and Management policy and procedure revised to include request for approval of a material change , including draft of notification to affected members 60 days prior to the implementation of change. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
6.8.4	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.	Substantial	Per PS 08.08, material changes are conveyed to DHH within one business day. This document does not address the content of the request.	MCO response: Completed. PS 08.08 Network Development and Management policy and procedure revised to include identification of short-term gaps as a result of the change and description of alternatives to fill gaps. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
6.8.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved.	N/A		
6.8.6	A material change in the CCN's provider network requires thirty (30) days advance written notice to	Full	Addressed in the Provider Network Development & Management Plan.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	affected members. For emergency situations, DHH will expedite the approval process.			
6.8.7	The CCN shall notify DHH/BHSF/Medicaid Coordinated Care Section within one (1) business day 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 CCN, or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)].	Full	Per PS 08.08, material changes are conveyed to DHH and the Enrollment Broker within one business day.	
6.8.8	This notification shall include: - Information about how the provider network change will affect the delivery of core benefits and services, and - The CCN's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of core benefits and services. - CCNs shall give hospitals and provider groups ninety (90) days notice prior to a contract termination without cause. - Contracts between the CCN and single practitioners are exempt from this requirement.	Substantial	PS 08.08 notes that an internal corrective action plan will be developed. However, the contents of the notification to DHH are not addressed in the documents provided.	MCO response: Completed. PS 08.08 Network Development and Management policy and procedure revised to include contents of the notification to DHH. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
6.9	**Patient-Centered Medical Home**			
6.9.0.1	The CCN will promote and facilitate	Full	Addressed in 08.08.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the capacity of all PCP practices to meet the recognition requirements of a NCQA PPC®-PCMH™ as jointly defined by NCQA or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation and DHH.			
6.9.0.2	The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home Accreditation.	Full	Addressed in Implementation Plan (undated) that was provided.	
6.9.1.1	The CCN shall provide a PCMH Implementation Plan within ninety (90) days of the Go Live date that identifies the methodology for promoting and facilitating PPC®-PCMH recognition and/or JCAHO PCH accreditation.	Minimal	Evidence of plan within 90 days of Go Live date not provided. PS 08.08 indicates that plan will be submitted. Plan is undated and includes 2012 results.	MCO response: Completed. PCMH Plan from "Go Live" identified, however, absent indication of DHH approval. All Plan templates updated to include DHH approval documentation. IPRO response: Determination unchanged. Updated plan and templates will be reviewed as part of next year's audit.
6.9.1.2	The implementation plan shall include, but not be limited to: payment methodology for payment to primary care practices for the specific purpose of supporting	Substantial	Requirements addressed in Plan provided with the exception of facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	MCO response: Completed. The language has been added to the S1056 CHS PCMH Plan 2013 including information about release of new utilization reports to network PCPs which includes this

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	necessary costs to transform and sustain NCQA PPC®- PCMH recognition or JCAHO PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters; provision of technical support, to assist in their transformation to PPC®-PCMH recognition or JCAHO PCH accreditation(e.g., education, training, tools, and provision of data relevant to patient clinical care management); facilitation of specialty provider network access and coordination to support the PCMH; and facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.			information. Further, in conjunction with the annual evaluation and approval, the plan will be updated and submitted for approval in 2014. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
6.9.2	The CCN shall meet or exceed the following thresholds and timetables for primary care practices to achieve NCQA PPC®- PCMH recognition or JCAHO PCH accreditation:	N/A		
6.9.2.1	By the end of the first year of operations in the region: o Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited.	N/A	CHS provided an undated PCMH Implementation Plan. The Plan notes that during 2012, 67 or 10.8% of 621 practices achieved recognition. DHH has extended the date for achieving the one year goal to June 2013. Final results pending at time of review.	
6.9.2.2	By the end of the second year of operation under the Contract: o Total of 30% of practices shall be NCQA PPC®-PCMH Level 1	N/A	Addressed in Plan.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	recognized or JCAHO PCH accredited; and o Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited.			
6.9.2.3	By the end of the third year of operation under the Contract: o Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; o Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and o Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	N/A	Addressed in Plan.	
6.9.3	The CCN shall submit an annual report indicating PCP practices that are NCQA PPC®-PCMH recognized, including the levels of recognition, or JCAHO PCH accreditation. Nurse practitioner-led practices may meet NCQA PPC®-PCMH Level 1 recognition requirements and notify the CCN, via attestation and supporting documentation, of the level achieved. The CCN may include these practices, and identify in reporting, the number of these practices that have met NCQA PPC®-PCMH Level 1 requirements.	Full	Addressed in Plan.	
6.9.4	The CCN shall participate in Patient-	Full	Addressed in Plan.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Centered Primary Care Collaborative activities.			
6.9.5	Subsequent renewal of the Contract beyond the initial three year period will require increased percentage of PCP practices to be NCQA recognized or JCAHO accredited to a total of eighty (80%) of practices.	N/A	Addressed in Plan.	
6.9.6	The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home Accreditation, and as defined in the terms and conditions of this RFP.	Full	Addressed in Implementation Plan (undated) provided.	
6.10	**Local Public Health Agencies and LSU Hospital Outpatient Clinics**			
6.10.0.1	The CCN should coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of	Full	Addressed in PS 08.08.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	understanding signed by OPH, BHSF (Medicaid), and the CCN.			
6.10.0.2	The CCN shall offer a Contract to all LSU Health Services Science Center hospital outpatient clinics that meet the criteria to become a primary care provider and may require LSU to meet the same terms and conditions as other primary care providers.	Full	LSU contracts were provided during readiness review.	
6.11	**Federal Quality Health Centers (FQHC)/Rural Health Clinics (RHC) Contracting Requirements**			
6.11.1	The CCN shall offer a Contract to all Federally Qualified Health Centers and, where applicable, Rural Health Clinics (free standing and hospital-based) in its GSA.	Full	Addressed in Provider Network Development & Management Plan.	
6.11.1.1	If an agreement cannot be reached with a FQHC/RHC, the CCN shall inform DHH and the CCN is not required to provide access to primary care services provided by the FQHC/RHC except in the following cases: the medically necessary services are required to treat an emergency medical condition; or FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the geographic service area within DHH's established time and distance travel standards.	Full	Addressed in Provider Handbook.	
6.11.2	The CCN must explicitly identify and inform potential enrollees and members the availability on FQHC/RHC services and limitation	Full	Addressed in Member Handbook.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	on access to those services. The CCN shall inform members of this right in their member handbooks.			
6.11.3	The CCN shall have written procedures for promptly transferring medical information needed for coordinating care with a FQHC. CCNs shall expect a sharing of information and data and appropriate CCN referrals from non-network FQHCs.	Full	Addressed in Provider Handbook.	
6.12	**School Based Health Clinics (SBHC)**			
6.12.1	SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.	N/A	Definition	
6.12.2	The CCN must make a good faith effort to collaborate with SBHCs in their GSAs. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures.	Full	Addressed in Provider Network Development & Management Plan.	
6.12.3	For those SBHCs that meet the criteria to become a primary care provider the CCN must offer a Contract and may require the SBHC to meet the same terms and conditions as other primary care providers.	Full	Addressed in Provider Network Development & Management Plan.	
6.13	**Subcontracting Requirements**			
6.13.0.1	The CCN shall provide enhanced primary care case management services specified in this RFP. The CCN may provide these services	Full	Addressed in IS 08.01.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	directly or may enter into subcontracts with entities that will authorize specified Medicaid State Plan services and provide care management to the members. The provision of Medicaid State Plan services will be delivered by the Louisiana Medicaid FFS provider network. Claims will be pre-processed by the CCN and paid by the State's FI. The CCN is ultimately responsible for all requirements of the Contract, including those performed by the CCN subcontractor(s).			
6.13.0.2	Any plan to delegate enhanced primary care management responsibilities of the CCN to a subcontractor shall be approved by DHH. Model subcontracts for care management providers shall be submitted within thirty (30) days after the Contract is signed by the CCN.	N/A		
6.13.0.3	After the execution of the Contract, the CCN shall submit to DHH for review and approval, prior to execution of the subcontract, any subcontract that is materially different from the model contract already approved by DHH for care management providers. DHH shall have the right to review and approve any and all subcontracts entered into for the provision of any activities under this RFP. The turnaround time for	N/A	Addressed in Provider Network Development & Management Plan.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	approval is expected to be thirty (30) days or less. Notification of amendments or changes to any contract which materially affects the subcontract, shall be provided to DHH prior to the execution of the amendment.			
6.13.0.4	The CCN shall not execute subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN 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.	Full	Addressed in CRE 08.01 Credentialing & Re-Credentialing Process.	
6.13.1	Required Terms and Conditions for Subcontracts - All subcontracts executed by the CCN pursuant to this section shall, at a minimum, include the following terms and conditions and no other terms and conditions agreed to by the CCN and its subcontractor shall negate or supersede the requirements in this RFP:	N/A		
6.13.1.1	Contain language that the subcontractor shall adhere to all	Full	Addressed in Provider Handbook and Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	requirements set forth for CCN subcontractors in the Contract between DHH and CCN and department issued Guides; and either physically incorporating these document as appendices to the subcontract or include language in the subcontract that the CCN shall furnish these documents to the provider upon request.			
6.13.1.2	Include a signature page which contains a CCN and provider name which are typed or legibly written, provider company with titles, and dated signature of all appropriate parties; (applicable for renewals as well). All subcontracts must be in writing and signed by the CCN and subcontractor.	Full	Addressed in the Provider Subcontract.	
6.13.1.3	Specify the effective dates of the subcontract agreement.	Full	Addressed in the Provider Subcontract.	
6.13.1.4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Full	Addressed in the Provider Subcontract.	
6.13.1.5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties, however the CCN may provide amendments by written notification through the CCN bulletin board, if mutually agreed to in terms of the	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	subcontract and with prior notice to DHH.			
6.13.1.6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract; however the CCN may provide amendments by written notification through CCN bulletins, if mutually agreed to in terms of the contract and with prior notice to DHH.	Full	Addressed in the Provider Subcontract.	
6.13.1.7	Specify that the CCN and subcontractor recognize that in the event of termination of the Contract between the CCN and DHH for any of the reasons described in the Contract, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Full	Addressed in the Provider Subcontract.	
6.13.1.8	Assure the subcontractor shall not, without prior approval of the CCN, enter into any subcontract or other agreement for any of the work	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	contemplated under the subcontract without approval of the CCN.			
6.13.1.9	Require that if any requirement in the subcontract is determined by DHH to conflict with the subcontract between DHH and the CCN, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Full	Addressed in the Provider Subcontract.	
6.13.1.10	Identify the population covered by the subcontract.	Full	Addressed in the Provider Subcontract.	
6.13.1.11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.	Full	Addressed in the Provider Subcontract.	
6.13.1.12	Specify that the subcontractor may not refuse to provide medically necessary or core preventive benefits and services to CCN members specified under the Contract between DHH and the CCN for non-medical reasons (except those services allowable under federal law for religious or moral objections).	Full	Addressed in the Provider Subcontract.	
6.13.1.13	Require that the subcontractor be currently licensed and/or certified	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the CCN.			
6.13.1.14	Specify the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan that are provided by the subcontractor, including all specific requirements outlined in the RFP and department issued Guides.	Full	Addressed in the Provider Subcontract.	
6.13.1.15	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Full	Addressed in the Provider Subcontract.	
6.13.1.16	Specify that the provider may not refuse to provide covered medically necessary or covered preventative services to members for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.	Full	Addressed in the Provider Subcontract.	
6.13.1.17	Include a provision which states the subcontractor is not permitted to encourage or suggest, in any way, that members be placed in state	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	custody in order to receive medical or specialized behavioral health services covered by DHH.			
6.13.1.18	Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to CCN members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Contract between DHH and the CCN). CCN members and their representatives shall be given access to and can request copies of the members' medical records, and subject to reasonable charges.	Full	Addressed in the Provider Subcontract.	
6.13.1.19	Include medical record requirements as specified in the Contract between DHH and the CCN.	Full	Addressed in the Provider Subcontract.	
6.13.1.20	Require that any and all member records including but not limited to administrative, financial, and medical be retained (whether electronic or paper) for a period of six (6) years after the last payment was made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	is complete. The exception to this requirement shall include records pertaining to once-in-a-lifetime events such as but not limited to appendectomy and amputations etc.) which must be retained indefinitely and may not be destroyed. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (La. R.S. 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods commence from the last date of treatment. After these minimum recordkeeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.			
6.13.1.21	Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office shall have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the Contract between	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	DHH and the CCN, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted to the CCN. Such evaluation, when performed, shall be performed with the cooperation of the CCN. Upon request, the CCN shall assist in such reviews.			
6.13.1.22	Require the subcontractor comply and submit to the CCN disclosure of information.	Full	Addressed in the Provider Subcontract.	
6.13.1.23	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the CCN and/or DHH or its designee.	Full	Addressed in the Provider Subcontract.	
6.13.1.24	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the CCN/subcontractor practices and/or the standards established by DHH or its designee.	Substantial	Provider Subcontract does not address "and/or standards established by DHH or its designee".	MCO response: Initiated. Efforts underway to revise the subcontract for implementation January 1, 2014. IPRO response: Determination unchanged. Subcontracts will be reviewed as part of next year's audit.
6.13.1.25	Require that the subcontractor comply with any corrective action	Substantial	Provider Subcontract should be modified to include: "initiated by the CCN and/or required by DHH".	MCO response: Initiated.

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	plan initiated by the CCN and/or required by DHH.			Efforts underway to revise the subcontract for implementation January 1, 2014. IPRO response: Determination unchanged. Subcontracts will be reviewed as part of next year's audit.
6.13.1.26	Specify any monetary penalties, sanctions or reductions in payment that the CCN may assess on the provider for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to respond to the CCN's request for information, the request to provide medical records, credentialing information, etc.; at the CCN's discretion or a directive by DHH, the CCN shall impose at a minimum, financial consequences against the provider as appropriate.	Full	Addressed in the Provider Subcontract.	
6.13.1.27	Provide for submission of all reports and clinical information required by the CCN for reporting purposes such as HEDIS, AHRQ, and EPSDT.	Full	Addressed in the Provider Subcontract.	
6.13.1.28	Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as described in Contract between DHH and the CCN.	Full	Addressed in the Provider Subcontract.	
6.13.1.29	Provide the name and address of the official payee to whom payment shall be made.	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.13.1.30	Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN.	Full	Addressed in the Provider Subcontract.	
6.13.1.31	Provide for prompt submission of complete and accurate claims information needed to make payment.	Full	Addressed in the Provider Subcontract.	
6.13.1.32	Provide that subcontractors must submit all clean claims for payment no later than twelve (12) months from the date of service.	Full	Addressed in the Provider Subcontract.	
6.13.1.33	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between DHH and the CCN, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the Contract between DHH and the CCN in its entirety in the subcontractor's agreement or by use of other language developed by the CCN and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Full	Addressed in the Provider Subcontract.	
6.13.1.34	Require the subcontractor to secure	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN's members and the CCN under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the CCN with written verification of the existence of such coverage.			
6.13.1.35	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services under the CCN Program.	Full	Addressed in the Provider Subcontract.	
6.13.1.36	Provide that the subcontract incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. In the event that changes in the subcontract as a result of revisions and applicable federal or state law materially affect the position of either party, the CCN and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities.	Full	Addressed in the Provider Subcontract.	
6.13.1.37	Specify that the CCN and subcontractor recognize that in the event of termination of the Contract	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	between the CCN and DHH for any of the reasons described in Contract between the CCN and DHH, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and its subcontractor's activities undertaken pursuant to the subcontract. The provision of such records shall be at no expense to DHH.			
6.13.1.38	Provide that the CCN and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the CCN member.	Full	Addressed in the Provider Subcontract.	
6.13.1.39	Include a conflict of interest clause as stated in the Contract between DHH and the CCN.	Full	Addressed in the Provider Subcontract.	
6.13.1.40	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in this RFP and Quality Companion Guide. The QAPI and UM requirements shall be included as part of the subcontract between the CCN and the subcontractor.	Full	Addressed in the Provider Subcontract and Provider Handbook	
6.13.1.41	Provide that all subcontractors shall give CCN immediate notification in writing by certified mail of any	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the CCN.			
6.13.1.42	Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care.	Full	Addressed in the Provider Subcontract.	
6.13.1.43	Specify that the subcontractor shall not assign any of its duties and/or responsibilities as required in the Contract between DHH and the CCN without the prior written consent of the CCN.	Full	Addressed in the Provider Subcontract.	
6.13.1.44	Specify that the CCN shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient: a) for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b) for any information the enrollee needs in order to decide among all relevant treatment options; c) for the risks, benefits, and consequences of treatment or non-treatment; and d) for the enrollee's right to participate in decisions regarding his or her health care, including the	Full	Addressed in the Provider Subcontract	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	right to refuse treatment, and to express preferences about future treatment decisions.			
6.13.1.45	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Full	Addressed in the Provider Subcontract.	
6.13.1.46	Contain no provision which restricts a subcontractor from subcontracting with another CCN or other managed care entity.	Full	Addressed in the Provider Subcontract.	
6.13.1.47	Provide that all records originated or prepared in connection with the subcontractor's performance of its obligations under the subcontract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the subcontractor in accordance with the terms and conditions of the Contract between DHH and the CCN. The subcontract must further provide that the subcontractor	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under the Contract between DHH and the CCN and as further required by DHH, for a period of six (6) years from the expiration date of the Contract between DHH and the CCN, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche or other electronic means, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request.			
6.13.1.48	State that compensation to the CCN or individuals that conduct utilization management activities is not structured so as to provide incentives for the individual or CCN to deny, limit, or discontinue medically necessary services to any member.	Full	Addressed in ADM 02.03 Financial Incentives.	
6.13.1.49	Provide that subcontractors, as	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.			
6.13.1.50	Provide that PCP's subcontract specify the maximum number of linkages the CCN may link to the PCP. The subcontract shall also stipulate that by signing the subcontract the PCP confirms that the PCP's total number of Medicaid members for the CCN Program will not exceed 2,500 lives.	Full	The Medical Home Enrollment Form includes space for provider to insert Member Capacity and there is a statement of what the state requirement is. The Provider Subcontract includes reference to provider compliance with the maximum number of members.	
6.14	**Provider-Member Communication Anti-Gag Clause**			
6.14.1	The CCN 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 benefits for such care or treatment are provided under the Contract, for the following: the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among relevant treatment options; the risks, benefits and consequences of treatment or non-treatment; and the member's right to participate in decisions regarding their health care, including, the	Full	Addressed in the Provider Subcontract.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	right to refuse treatment, and to express preferences about future treatment decisions.			
6.14.2	Any CCN that violates the anti-gag provisions shall be subject to intermediate sanctions.	N/A		
6.14.3	The CCN shall comply with the provisions 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.	Full	Addressed in the Provider Subcontract.	
6.14.4	The CCN shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Full	Addressed in Provider Development & Management Plan.	
6.14.5	The CCN shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and	Full	Addressed in Provider Development & Management Plan and Provider Handbook.	
6.14.6	The CCN shall identify deficiencies or areas for improvement, and take corrective action.	Full	Addressed in Provider Development & Management Plan and Provider Handbook.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.0.0	The CCN shall possess the expertise and resources to ensure the delivery of enhanced primary care case management and PCP care management services to CCN members in accordance with the provisions of this RFP, and Medicaid rules and regulations. These services shall include, but not be limited to, referral to and coordination of authorized services to any of the Medicaid providers where a referral has been made; chronic care management; member services, and quality management.	Full	Addressed in Policy CM 01.43 Care Coordination, Continuity of Care and Care transition.	
7.1	**Care Management**			
7.1.0.1	Care management is defined as the overall system of medical management encompassing, but not limited to, Referrals, Utilization Management, Case Management, Care Coordination, Continuity of Care, Care Transition Chronic Care Management, and Independent Review. The CCN shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid authorized services provided to the member.	Full	Addressed in Policy CM 01.43 Care Coordination, Continuity of Care and Care Transition.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.0.2	The CCN shall be responsible for ensuring: member's health care needs and services are planned and coordinated through the CCN PCP; accessibility of services and promoting prevention through qualified medical home practices which requires the provision for reasonable and adequate hours of operation including 24/7 availability of information, referral, and treatment for emergency medical conditions; and care coordination and referral activities, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services without compromise to quality of care. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.	Full	Addressed in Policy #CM 01.43 Care Coordination, Continuity of Care and Care Transition and Policy CM 01.04 24 Hour Nurse Line.	
7.1.1	**Referrals**			
7.1.1.0.1	The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care.	Full	Addressed in Policy CM 01.43 Care Coordination, Continuity of Care and Care Transition and Policy CM 01.28 Referral Codes.	
7.1.1.0.2	The CCN shall provide the coordination necessary for referral as appropriate, of CCN members to, including but not limited to,	Full	Addressed in Policy CM 01.43 Care Coordination, Continuity of Care and Care Transition and Policy CM 01.28 Referral Codes.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	specialty physicians, hospitals, lab and x-ray, ancillary service providers, and home health; that are available through fee-for service Medicaid providers.			
7.1.1.0.3	The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider.	Full	Addressed in Policy CM 01.43.	
7.1.1.0.4	The referral system must include processes to ensure monitoring and documentation of specialty health care services (e.g., medications prescribed, treatment received, recommendations for care), and follow up are included in the PCPs member medical record.	Full	Addressed in Policy QM 08.03 Medical Record Documentation Standards.	
7.1.1.1	The CCN shall submit referral system policies and procedures to DHH for review and approval within thirty (30) days from the date the Contract is signed by the CCN, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following:	Substantial	Policies provided. The requirement for DHH approval was not addressed in the plan's general policy INT.01 regarding policy management. It is recommended that individual policies be revised to include this requirement.	MCO response: Completed. As of 10/25/13, Policy INT 01.01 has been updated to include policy submission to the state within 30 days of contract execution and annually thereafter. Additionally, in conjunction with the annual review and approval of policies, all pertinent policies will be updated to include policy submission to the state. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.
7.1.1.1.1	When a referral from the member's PCP is and is not required;	Full	Addressed in Policy CM 01.28 Referral Codes.	
7.1.1.1.2	Process for member referral to an Medicaid provider who has the	Full	Addressed in Policy CM 01.43 Care Coordination, Continuity of Care, Care Transition and Policy CM 01.28	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appropriate training or expertise to meet the particular health needs of the member;		Referral Codes.	
7.1.1.1.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Full	Addressed in Policy CM 01.28 Referral Codes.	
7.1.1.1.4	Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;	Full	Addressed in Policy CM 01.28 Referral Codes.	
7.1.1.1.5	Process for member referral for case management;	Full	Addressed in Policy CM 01.25 Referrals to Case Management.	
7.1.1.1.6	Process for member referral for chronic care management;	Full	Addressed in Policy CM 01.38 Chronic Care Management.	
7.1.1.1.7	Prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of the provider‘s family has a financial relationship.	Full	Addressed in Provider Handbook.	
7.1.1.1.8	Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP‘s member medical record.	Full	Addressed in Policy QM 08.03 Medical Record Documentation Standards.	
7.1.1.1.8.1	There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued	Full	Addressed in Policy QM 08.03 Medical Record Documentation Standards.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	communication of patient information between the specialty health care provider and the primary care provider; and			
7.1.1.1.9	Process for referral of members for services that are outside of the core benefits and services which will continue to be provided by enrolled Medicaid providers.	Full	Addressed in Policy CM 01.43.	
7.1.1.1.10	DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems. In the event a referral is made via the telephone, the CCN shall ensure that referral data, including the final decision, is maintained in a data file that can be accessed electronically by the CCN, the provider and DHH.	Non-Compliance	Referral policies do not address this requirement. It is recommended that the referral policies be amended to include a process for documenting referral data in an accessible electronic file.	MCO response: Completed. CHS-LA does currently offer providers a web-based portal through which they can determine the status of a Prior Authorization or Pre-Certification request, regardless of the method (telephonic or otherwise), including the final decision. As a PCCM model of care, CHS-LA expects the Medical Home provider to directly refer members for medically necessary services. CHS-LA does not require PCPs to submit referrals to specialty care or ancillary service providers through CHS-LA, but, rather, to document referrals within their medical records. PCP referrals to specialty or ancillary providers that do not require Prior Authorization or Pre-Certification would not be captured by the CCN. IPRO response: Determination is unchanged. Plan response is noted regarding the PCCM model. Provider portal will be reviewed as part of next year's audit. It is recommended that the portal capture not only the referral, but the outcome of the referral as well as part of its UM and CM processes.
7.1.5	**Care Coordination, Continuity of Care, and Care Transition**			

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.5.0.1	The CCN shall develop and maintain effective coordination, continuity of care, and care transition activities which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of primary care services with other services that are reimbursed fee-for-service by DHH.	Full	Addressed in Policy CM 01.43.	
7.1.5.0.2	The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.	Full	Addressed in Policy CM 01.43.	
7.1.5.1	Coordination of Medicaid State Plan Services - The CCN shall be required to provide service authorization, refer, coordinate, and/or provide assistance in scheduling medically	Full	Addressed in Policy CM 01.43.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	necessary services consistent with the standards as defined in Louisiana State Medicaid Plan regarding service limits and service authorization requirements with the exception of physician visits.			
7.1.5.1.0.1	The CCN shall have policies and processes to authorize physician visits in excess of the 12 visit limit consistent with adult prior authorization requirements currently in Medicaid FFS. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services authorizations are not subject to this 12 service limit.	Full	Addressed in Policy UM 08.04 Service Authorizations, Determinations, and Notifications.	
7.1.5.1.0.2	Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by DHH are the final authority regarding services.	Full	Addressed in Policy CM 01.43.	
7.1.5.1.0.3	The CCN shall be responsible to coordinate the following Louisiana Medicaid State Plan services: Inpatient Hospital Services, Inpatient Hospital Services, Outpatient Services, Ancillary Medical Services, EPSDT/Well Child Visits, Emergency Medical Services, Communicable Disease Services, Emergency Medical Transportation, Home Health Services, Family Planning Services, Basic Behavioral Health Services, School-Based Health Clinic Services, Physician Services, Maternity Services, Organ	Full	Addressed in Policy CM 01.43.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Transplant and Related Services, Chiropractic Services, Rehabilitation Therapy Services (physical, occupational, and speech therapies), Federally Qualified Health Clinics, (FQHC)/Rural Health Clinics (RHC) Services.			
7.1.5.1.1	The CCN will not be responsible to pre-process or provide service authorization, but shall provide any required referrals and coordination, for the following services: Services provided through DHH's Early Step Services (IDEA Part C Program Services); Dental Services; Personal Care Services (EPSDT and LTPCS); Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services; Home & Community-Based Waiver Services; Hospice Services; Non-Emergency Transportation; School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district; Nursing Facility Services; Pharmacy (Prescription Drugs); Specialized Behavioral Health Services; Targeted Case Management; Durable Medical Equipment and certain supplies; and Prosthetics and orthotics; and	Full	Addressed in Policy UM 08.04 Service Authorizations, Determinations and Notifications.	
7.1.5.1.2	The CCN shall implement DHH approved care coordination and continuity of care policies and	N/A		

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	procedures that meet or exceed the following requirements:			
7.1.5.1.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.2	Coordinate care between PCPs and specialists;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.3	Coordinate care for out-of-network services, including specialty care services;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.4	Coordinate CCN provided services with services the member may receive from other health care providers;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.6	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable and other applicable state or federal laws;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Full	A Hospital Discharge Planning Workflow has been prepared.	
7.1.5.1.2.8	Coordinate with hospital and/or	Full	A Hospital Discharge Planning Workflow has been	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	institutional discharge planning that includes post-discharge care as appropriate;		prepared.	
7.1.5.1.2.9	Identify members using emergency department services inappropriately and assist in scheduling follow-up care with PCP and/or appropriate specialists;	Full	Addressed in Policy CM 01.43.	
7.1.5.1.2.10	Document authorized referrals in its utilization management system; and	Full	Addressed in Policy CM 01.25 Referrals to Case Management.	
7.1.5.1.2.11	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 CCN. The CCN 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.	Substantial	Policy CM 01.43 states that services will be continued unless member is transferred prior to "this timeframe" but the 90 day timeframe is not specified.	MCO response: Completed. Policy CM 01.43 has been updated to include 90 day verbiage and 30 day verbiage and transition between plan requirements. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.
7.1.5.1.4	Continuity for Behavioral Health Care	N/A		
7.1.5.1.4.1	The PCP shall provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	Full	Addressed in Policy CM 01.36 Behavioral Health Care Coordination.	
7.1.5.1.4.2	In order to ensure continuity and coordination of care for members	Full	Addressed in Policy CM 01.36.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	who needs specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system or other managed care arrangement responsible for specialized behavioral health services (as applicable) for services.			
7.1.5.1.4.3	In any instance when the member presents to the network provider, including calling the CCN's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the CCN shall instruct the member to seek help from the nearest emergency medical provider. The CCN shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Full	Addressed in Policy CM 01.36.	
7.1.5.1.4.4	The CCN 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 provider.	Full	Addressed in Policy CM 01.36.	
7.1.5.1.4.5	The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and	Full	Addressed in Policy CM 01.36.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	agencies that will promote continuity, as well as, cost effectiveness of care.			
7.1.5.1.4.6	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.	Full	Addressed in Policy CM 01.36.	
7.1.5.1.4.7	The CCN shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	Full	Addressed in Policy CM 01.36.	
7.1.5.2	Care Transition	N/A		
7.1.5.2.1	The CCN shall provide active assistance to members when transitioning to another provider (CCN or Medicaid FFS programs).	Full	Addressed in Policy CM 01.43.	
7.1.5.2.2	The receiving CCN shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period. The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this transition period, the receiving CCN shall be responsible for notification	Substantial	Policy CM 01.43 discusses transitioning to another plan (CCN), but the 30 calendar day transition period does not appear to be stated. It is recommended that this policy be revised to include the 30 day timeframe as the transition period, and that during this period the receiving plan shall be responsible for notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services and all other new member requirements.	MCO response: Completed. Policy CM 01.43 has been updated to include 90 day verbiage and 30 day verbiage and transition between plan requirements. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.			
7.1.5.2.3	If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's hospitalization status within five (5) business days.	Full	Addressed in Policy CM 01.43.	
7.1.5.2.4	Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing CCN. A copy of the member's medical record and supporting	Full	Addressed in Policy CM 01.43.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.			
7.1.5.2.5	Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.	Full	Addressed in Policy CM 01.43.	
7.1.5.2.7	The CCN shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the DHH Medicaid Coordinated Care Section staff and staff from other CCNs to ensure a safe and orderly transition.	Full	Addressed in Policy CM 01.43.	
7.1.5.2.8	When relinquishing members, the CCN is responsible for timely notification to the receiving CCN regarding pertinent information related to any special needs of transitioning members. The CCN, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with CCN and service information, emergency numbers and instructions on how to obtain services.	Full	Addressed in Policy CM 01.43.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.6	**Case Management**			
7.1.6.0.1	The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, other services, and behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs.	Full	Addressed in Care Management Program Description.	
7.1.6.0.2	The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, and behavioral health needs of the member.	Full	Addressed in Care Management Program Description.	
7.1.6.0.3	The case manager should assist/facilitate the discharge planning process when assistance is needed to ensure patients receive care deemed medically necessary by the treating physician.	Full	Addressed in Policy UM 08.01 Hospital Inpatient and Discharge Planning Process and Policy UM 08.01.01 Hospital Discharge Planning Workflow.	
7.1.6.0.4	The CCN shall submit case management program policies and procedures to DHH for approval within thirty (30) days of the date the Contract is signed by the CCN and annually thereafter.	Substantial	Case management policies provided. Policies reviewed do not include this requirement. This requirement also could not be located in the plan's general policy INT.01 regarding policy management. It is recommended that individual policies be revised to include this requirement.	MCO response: Completed. As of 10/25/13, Policy INT 01.01 has been updated to include policy submission to the state within 30 days of contract execution and annually thereafter. Additionally, in conjunction with the annual review and approval of policies, all pertinent policies will be

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				updated to include policy submission to the state. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.
7.1.6.1	Case Management Functions	N/A		
7.1.6.1.1	Case management functions shall include, but are not limited to:	N/A		
7.1.6.1.1.1	Early identification of members who have or may have special needs;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.2	Assessment of a member's risk factors;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.4	Development of an individualized treatment care plan which must be: developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member; approved by the CCN in a timely manner if required by the CCN; and in compliance with applicable QA and UM standards;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.5	Referrals and assistance to ensure timely access to providers;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Full	Addressed in Care Management Program Description.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.6.1.1.7	Monitoring;	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.8	Continuity of care; and	Full	Addressed in Care Management Program Description.	
7.1.6.1.1.9	Follow-up and documentation.	Full	Addressed in Care Management Program Description.	
7.1.6.1.2	Case Management Policies and Procedures - The CCN shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from date the Contract is signed by the CCN, annually thereafter, and subsequent to any revisions. Case Management policies and procedures shall, at a minimum, include the following elements:	Substantial	Case Management policies/procedures provided. Policies reviewed do not include this requirement. This requirement also could not be located in the plan's general policy INT.01 regarding policy management. It is recommended that individual policies be revised to include this requirement.	MCO response: Completed. As of 10/25/13, Policy INT 01.01 has been updated to include policy submission to the state within 30 days of contract execution and annually thereafter. Additionally, in conjunction with the annual review and approval of policies, all pertinent policies will be updated to include policy submission to the state. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.
7.1.6.1.2.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Full	Addressed in Care Management Program Description.	
7.1.6.1.2.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Full	Addressed in Care Management Program Description.	
7.1.6.1.2.3	The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care 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	Full	Addressed in Care Management Program Description.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	procedures shall be designed to accommodate the specific cultural and linguistic needs of the CCN's members. Procedures must describe collaboration processes with member's treatment providers;			
7.1.6.1.2.4	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Full	Addressed in Care Management Program Description.	
7.1.6.1.2.5	Procedures and criteria for making referrals to specialists and subspecialists and follow-up of those referrals;	Full	Addressed in Care Management Program Description.	
7.1.6.1.2.6	Procedures and criteria for maintaining treatment care plans and referral services when the member changes PCPs; and	Full	Addressed in Policy CM 01.28 Referral Codes and Policy CM 01.25 Referrals to Case Management.	
7.1.6.1.2.7	Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.	Full	Addressed in Policy CM 01.38 Chronic Care Management and Care Management Program Description.	
7.1.6.1.3	Identifying Individuals with Special Health Care Needs	N/A		
7.1.6.1.3.1	The CCN shall implement mechanisms to assess each Medicaid member identified or has self identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or	Full	Addressed in Policy CM 08.10 Special Health Care Needs Service Continuity.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	regular care monitoring to the CCN or PCP. The assessment mechanisms must use appropriate health care professionals. The CCN shall have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.			
7.1.6.1.3.2	The CCN shall utilize historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for meeting SHCN criteria. The CCN must identify members with potential SHCN within ninety (90) days of receiving the member's historical claims data (if available).	Full	Addressed in Policy CM 08.10 Special Health Care Needs Service Continuity.	
7.1.6.1.3.3	CCN PCPs shall identify members who meet SHCN criteria to the CCN. The PCP can identify members as having special needs at any time the member presents with those needs. The CCN must assess those members within ninety (90) days of identification. The assessment must be done by appropriate healthcare professionals.	Minimal	This requirement is addressed in Policy CM 08.10 (Special Health Care Needs Service Continuity). However, case management reports reviewed for the 2012 year, and through the 2nd quarter of 2013, indicate that the majority of assessments have not been conducted in this timeframe. For the 6 months ended 6/30/13, nearly 94% of assessments completed during this period were non compliant with the 90 day timeframe. The plan has recognized the non compliance and has put action plans in place to address this concern. Case management triggers and risk stratification methods are being revised to modify the membership base considered to be eligible for the care management and chronic care management programs, in an effort to redefine the number of assessments to be completed. Staff anticipates the percentage of assessments completed within acceptable timeframes to improve in	MCO response: Initiated. Internal CHS CAP instituted. Progress on the CAP will be monitored through the SQ039 report quarterly and addressed in UMC and QIC meetings. IPRO response: Determination unchanged. Updated action plans and meeting minutes will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			the latter part of 2013. It is recommended that these efforts continue. The plan should also ensure that there is adequate staffing for these assessments.	
7.1.6.1.3.4	Assessments that determine a course of treatment or regular care monitoring is appropriate shall result in a referral for Case Management. However, during the phase-in implementation of the Coordinated Care Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date.	Full	DHH indicated that this requirement was extended during the phase in implementation of the program.	
7.1.6.1.3.5	The CCN must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist(s) (for example, through a standing referral) as appropriate for the member's condition and identified needs.	Full	Addressed in Policy CM 08.10 Special Health Care Needs Service Continuity.	
7.1.6.1.4	Case Management Reporting Requirements - The CCN shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to the due date of those reports. The case management reports shall include, at a minimum: - Number of members identified with potential special healthcare	Substantial	Case Management Reports are generated quarterly and include each of these requirements except for the number of treatment plans completed. These data are not a part of the quarterly case management report (SQ039). It is recommended that the reporting be modified to capture these data.	MCO response: SQ039 is a state mandated report and the template does not allow for information, such as number of treatment plans completed, which is not included in the template to be submitted on this report. As part of an internal CAP developed regarding Care Management reporting mentioned above in 7.1.6.1.3.3, CHS will develop internal report to have this data available. CHS will also recommend to DHH that this data point be included in future versions of the template for the SQ039 report. IPRO response: Determination is unchanged. The absence of the

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	needs utilizing historical claims data; - Number of members with special healthcare needs identified by the member's PCP; - Number of identified members with assessments; - Number of members with assessments resulting in a referral for Case Management; and - Number of treatment care plans completed.			"number of treatment plans" on form SQ039 is noted and will be discussed with DHH. In the interim, the plan, as it notes in its response, should develop an internal reporting system.
7.1.7	**Chronic Care Management Program (CCMP)**			
7.1.7.0	The CCN shall implement a Chronic Care Management Program (CCMP) for members with chronic conditions. The Chronic Care Management Program shall:	Full	Addressed in Policy CM 01.38 Chronic Care Management.	
7.1.7.0.1	Emphasize prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in Policy CM 01.38.	
7.1.7.0.2	Encourage the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in Policy CM 01.38.	
7.1.7.0.3	Address co-morbidities through a whole-person approach; and	Full	Addressed in Policy CM 01.38.	
7.1.7.0.4	Promote chronic care management strategies, such as: referral processes; after hours protocols, and targeted management to focus on those in greatest need.	Full	Addressed in Policy CM 01.38.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.7.1	The CCN shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Diabetes; and Congestive heart failure.	Full	Addressed in Policy CM 01.38.	
7.1.7.1.0	The CCN 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; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1	CCMP Policies and Procedures - The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually and subsequent to any revisions. The CCN shall develop and implement policies and procedures that:	Substantial	CCMP policies provided. Policies reviewed do not include this requirement. This requirement also could not be located in the plan's general policy INT.01 regarding policy management. It is recommended that individual policies be revised to include this requirement.	MCO response: Completed. As of 10/25/13, Policy INT 01.01 has been updated to include policy submission to the state within 30 days of contract execution and annually thereafter. Additionally, in conjunction with the annual review and approval of policies, all pertinent policies will be updated to include policy submission to the state. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.
7.1.7.1.1.1	Include the definition of the target population;	Full	Addressed in Policy CM 01.38.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.7.1.1.2	Include member identification strategies;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.6	Include methods for informing and educating members and providers;	Full	Addressed in Policy CM 01.38 and Care Management Program Description.	
7.1.7.1.1.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.9	Address co-morbidities through a whole person approach;	Full	Addressed in Policy CM 01.38.	
7.1.7.1.1.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Full	Addressed in Policy CM 01.38 and Care Management Program Description.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.7.1.1.11	Include Program Evaluation requirements.	Full	Addressed in Policy CM 01.38.	
7.1.7.1.2	Predictive Modeling - The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.	Full	Addressed in Policy CM 01.38.	
7.1.7.1.2.1	The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually thereafter, and prior to any changes. These specifications shall include but are not limited to:	Substantial	Policies provided. Policies reviewed do not include this requirement. This requirement also could not be located in the plan's general policy INT.01 regarding policy management. It is recommended that individual policies be revised to include this requirement.	MCO response: Completed. As of 10/25/13, Policy INT 01.01 has been updated to include policy submission to the state within 30 days of contract execution and annually thereafter. Additionally, in conjunction with the annual review and approval of policies, all pertinent policies will be updated to include policy submission to the state. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.
7.1.7.1.2.2	A brief history of the tool's development and historical and current uses;	Substantial	Brief history of the tool's development was not available in PCCM D.15 Predictive Modeling Methodology, or in any of the CCMP or Care Management policies.	MCO response: Completed. The Predictive Modeling Methodology has been updated with a history of the tool's development and historical and current uses. IPRO response: Determination unchanged. Updated methodology will be reviewed as part of next year's audit.
7.1.7.1.2.3	Medicaid data elements to be used for predictors and dependent measure(s);	Full	Addressed in PCCMD.15 Predictive Modeling Methodology.	
7.1.7.1.2.4	Assessments of data reliability and model validity;	Full	Addressed in PCCMR9CHS SQ216 QAPI Impact and Effectiveness Report.	
7.1.7.1.2.5	A description of the rules and strategy to achieve projected	Full	Addressed in PCCMD.15 Predictive Modeling Methodology.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	clinical outcomes and how clinical outcomes shall be measured; and			
7.1.7.1.2.6	A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.	Full	Addressed in PCCMR9CHS SQ216 QAPI Impact and Effectiveness Report.	
7.1.7.1.3	Chronic Care Management Program Reporting Requirements - The CCN shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports. The CCMP reports shall contain at a minimum: - Total number of members; - Number of members in each stratification level for each chronic condition; and - Number of members who were disenrolled from the program and an explanation as to why they were disenrolled. The CCN shall submit an annual CCMP evaluation.	Full	Addressed in CCMP Summary Report (SQ039).	
7.2	**Behavioral Services**			
7.2.0	The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the	Full	Addressed in Policy CM 01.36 Behavioral Health Coordination.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, or licensed professional counselors either in mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan. Behavioral health services shall be divided into two levels:			
7.2.1	Basic behavioral health services shall include, but not be limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan; and	Full	Addressed in Policy CM 01.36.	
7.2.1.1	Specialized behavioral health services shall include, but not be limited to, services specifically defined in state plan and provided by psychiatrists, psychologists, and/or mental health rehabilitation providers to those members with a primary diagnosis of a mental and/or behavioral disorder.	Full	Addressed in Policy CM 01.36.	
7.2.1.2	Basic Behavioral Health Services - The CCN shall be responsible for ensuring the provision of basic behavioral health benefits and services to all members. The CCN	Full	Addressed in Policy CM 01.36.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	PCPs shall utilize the screening tools and protocols approved by DHH.			
7.2.2	The CCN shall be responsible for providing basic behavioral health benefits and services to all members. The CCN shall utilize the screening tools and protocols approved by DHH. Basic behavioral health services/benefits shall include, but may not be limited to: - Screening, Prevention and Referral: - Screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (the EPSDT benefit guarantees coverage of —screening services which must, at a minimum, include —a comprehensive health and developmental history – including assessment of both physical and mental health: - Behavioral health services provided in the member's PCP or medical office as described under the —Basic Services section above(e.g., DO, MD); - Outpatient non-psychiatric hospital services, based on medical necessity; and - Those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given episode of care.	Full	Addressed in Policy CM 01.36.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.3	**Emergency Services**			
7.3.0	The CCN shall insure that emergency and post-stabilization services are coordinated without the requirement of prior authorization of any kind; and shall advise all CCN members of the provisions governing the use of emergency services. The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	Full	Addressed in the Provider Manual.	
7.4	**Family Planning Services**			
7.4.0	The CCN shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The CCN family planning services shall also include preconception care services for members to optimize member health entering pregnancy. The CCN shall agree to make available all family planning services to CCN members as specified in on the Louisiana Medicaid State Plan.	Full	Addressed in Member Handbook and Policy UM 08.04 Service Authorizations, Determinations and Notifications.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the CCN's provider network without any restrictions. The out-of-network Medicaid enrolled family planning services provider will submit the claim to the CCN and will be reimbursed no less than the Medicaid rate in effect on the date of services by DHH's FI. CCN members should be encouraged by the CCN to receive family planning services through the CCN's network of providers to ensure continuity and coordination of the member's total care.			
7.6	**Women's Health Services**			
7.6.0	The CCN shall ensure direct access by female members to an OB/GYN within the provider's network (if the OB/ GYN is the member's PCP) or a OB/ GYN Member provider for routine OB / GYN services regardless of whether the PCP (general practitioner, family practitioner or internist) provides such services. Routine gynecological care shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment provided within sixty (60) days following either visit if related to a conditions	Full	Addressed in Policy 08.01 Direct Access to Services, OB/ GYN.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	diagnosed or treated during the visits, and any care related to a pregnancy.			
7.7	**Cultural Considerations**			
7.7.0	The CCN shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CCN shall have written procedures for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, members with limited English Proficiency at no cost to the member. The provision for any needed interpretation services shall be the responsibility of the CCN.	Full	Addressed in Policy INT TTY/Translation Services-Communication-Member Assistance.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.1.2	**Utilization Management**			
7.1.2.0	The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review including service authorization and medical necessity review and are in accordance with the requirements set forth in this section and this RFP. The CCN shall submit UM policies and procedures to DHH within thirty (30) days from the date the Contract is signed by the CCN for written approval, and annually and subsequent to any revisions.	Full	Addressed in Service Authorization and Notice P&P.	
7.1.2.1	The UM Program policies and procedures shall meet all URAC or NCQA standards and include medical management criteria and practice guidelines that: are adopted in consultation with subcontracting health care professionals; are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of the members; and are reviewed annually and updated periodically as appropriate.	Full	Policy notes that URAC standards are followed as well as Milliman Clinical Guidelines.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.2.0	The policies and procedures shall include but not be limited to:	N/A		
7.1.2.2.0.1	The methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;	Full	Addressed in Policy 08.03 Clinical Review.	
7.1.2.2.0.2	The data sources and clinical review criteria used in decision making;	Full	Addressed in Policy 08.03.	
7.1.2.2.0.3	The appropriateness of clinical review shall be fully documented;	Full	Addressed in Policy 08.03.	
7.1.2.2.0.4	The process for conducting informal reconsiderations for adverse determinations;	Minimal	File review revealed that 3/10 cases did not include communication to the members that they have an opportunity to present evidence on their behalf. One case did not meet the timeliness standard (i.e., within one working day) by one day. In other cases, it was difficult to determine the time to reach a determination. Plan indicated that it has implemented a system enhancement that includes a field for when clinical information is received.	MCO response: Completed. Staff re-directed to send letters to all three parties for denials. Monitoring--Additional audits to be conducted for 90 days targeting this component to ensure compliance. LOI letter revised to include State Fair Hearing Process - pending DHH approval. IPRO response: Determination unchanged. Updated process and LOI letter will be reviewed as part of next year's audit. File review will also be conducted.
7.1.2.2.0.5	Mechanisms to ensure consistent application of review criteria and compatible decisions; and	Full	Addressed in Policy 08.03.	
7.1.2.2.0.6	Data collection processes and analytical methods used in assessing utilization of healthcare services; and provisions for assuring confidentiality of clinical and proprietary information.	Substantial	Substantially addressed in Policy 08.03. However, a clause assuring the confidentiality of information was not included.	MCO response: Completed. Policy 08.03 has been updated to include a clause assuring the confidentiality of information. IPRO response: Determination unchanged. Updated policy will be

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				reviewed as part of next year's audit.
7.1.2.2.1	The CCN must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	N/A		
7.1.2.2.1.1	The vendor must be identified if the criteria was purchased;	Full	Addressed in Policy CM 01.41 Practice Guidelines.	
7.1.2.2.1.2	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;	Full	Addressed in Policy 08.03. Milliman Clinical Guidelines (MCG) are followed.	
7.1.2.2.1.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Full	Addressed in Policy 01.41 Practice Guidelines.	
7.1.2.2.1.4	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 CCN medical director or other qualified and trained professionals.	Full	Addressed in Policy 08.04 Service Authorization Determination and Notification. RNs licensed in Louisiana with a minimum of three years experience and trained in URAC standards. CMO provides ongoing oversight.	
7.1.2.2.2	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request.	Full	Addressed in CM01.41 Practice Guidelines.	
7.1.2.2.3	The CCN shall have sufficient staff with clinical expertise and training to apply service authorization	Full	Addressed in Policy 08.03 Clinical Review. CMO provides oversight. Peer review and Provider Advisory Committee are involved as necessary.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	medical management criteria and practice guidelines.			
7.1.2.2.4	The CCN shall use the medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations.	Full	Addressed in Policy 08.03 Clinical Review.	
7.1.2.2.5	The CCN must identify the qualifications of staff who will determine medical necessity.	Full	Addressed in CM 01.10 Clinical Assessment and Care Plan Development. Clinicians must conduct reviews to determine medical necessity. Confirmed in the file review.	
7.1.2.2.6	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Full	RNs and Physicians conduct reviews. Confirmed in the file review.	
7.1.2.2.7	The CCN 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. 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 competence	Full	Clinicians must be currently licensed. Review of Appeals, Informal Reconsiderations and denials confirmed that all were reviewed by either nurses or physicians.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	or moral character; and 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.			
7.1.2.2.8	The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The CCN 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 CCN 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.	Full	Avoidance of duplication of services is addressed in 08.04. Case review indicated that some services were denied (e.g, MRIs) because they were not deemed to be medically necessary, using Milliman criteria.	
7.1.2.2.8.1	The CCN shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the	Full	Included in Policy 08.04.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN can provide the service through an in-network or out-of-network provider for a lower level of care.			
7.1.2.2.9	The CCN 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.	Full	Addressed in Policy ADM 02.03.	
7.1.2.2.10	The CCN shall disseminate Utilization Management practice guidelines to all affected providers, members, and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Full	Addressed in UM Program Description.	
7.1.2.2.11	The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity.	Full	Addressed in UM Program Description.	
7.1.2.2.12	The CCN Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:	Full	Addressed in UM Program Description.	
7.1.2.2.12.1	Identification of the enrollee;	Full	Addressed in UM Program Description.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.2.12.2	The name of the enrollee's physician;	Full	Addressed in UM Program Description.	
7.1.2.2.12.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Full	Addressed in UM Program Description.	
7.1.2.2.12.4	The plan of care;	Full	Addressed in UM Program Description.	
7.1.2.2.12.5	Initial and subsequent continued stay review dates;	Full	Addressed in UM Program Description.	
7.1.2.2.12.6	Date of operating room reservation, if applicable;	Non-Compliance	Date of Operating Room Reservation is not included in the UM Program Description and should be added.	MCO response: Completed. UM Program Description has been updated to add 'Date of Operating room Reservation'. IPRO response: Determination unchanged. Updated Program Description will be reviewed as part of next year's audit.
7.1.2.2.12.7	Justification of emergency admission, if applicable.	Full	Addressed in UM Program Description.	
7.1.2.3	Utilization Management Committee	Full	Addressed in UM Program Description.	
7.1.2.3.1	The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the CCN as appropriate and supports the QAPI Program.	Full	Addressed in UM Program Description.	
7.1.2.3.2	The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less	Full	Quarterly UM Committee Meeting agendas were submitted.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting.			
7.1.2.3.3	UM Committee responsibilities include: monitoring providers' requests for rendering healthcare services to its members; monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling; reviewing the effectiveness of the utilization review process and making changes to the process as needed; approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task; monitoring consistent application of medical necessity criteria; application of clinical practice guidelines; monitoring over- and underutilization; review of outliers, and Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.	Full	Committee Meeting Minutes were submitted. Topics included Clinical reviews, audit results, UM work plan etc.	
7.1.2.4	Medical Record Review Strategy - The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process.	Full	Medical Record documentation policy addressed in QM 08.03 Medical Record Documentation Standards.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	The strategy shall be provided within thirty (30) days from the date the Contract is signed by the CCN and annually thereafter.			
7.1.2.4.1	The strategy shall include, at a minimum, the following: designated staff to perform this duty; the method of case selection; the anticipated number of reviews by practice site; the tool the CCN shall use to review each site; and how the CCN shall link the information compiled during the review to other CCN functions (e.g. QI, credentialing, peer review, etc.). The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.	Full	Addressed in QM 08.03 Medical Record Documentation Standards. 08.03.01 includes the medical record audit tool. Results are shared with Peer Review Committee, Credentialing and Quality Management.	
7.1.2.4.2	The CCN shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The CCN shall review each site at least one (1) time during each two (2) year period.	Full	Addressed in QM08.03 Medical Record Documentation Standards.	
7.1.2.4.3	The CCN shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary	Full	Addressed in QM08.03 Medical Record Documentation Standards.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	in specific instances.			
7.1.2.4.4	The CCN shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Full	Medical Record Review Summaries are prepared quarterly.	
7.1.2.5	Reporting Requirements - The CCN shall submit utilization management reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the CCN of additional required reports no less than 30 days prior to due date of those reports.	Full	UM Program Evaluation summarizes UM activities.	
7.1.2.6	Service Authorization - Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	N/A	Addressed in 08.04 Service Authorizations, Determinations and Notifications	
7.1.2.6.0.1	The CCN shall provide service authorization only for those medically necessary services that require authorization under the Medicaid FFS system, with the exception of physician services as specified in § 7.1.5.1.1.	Full	Addressed in 08.04 Service Authorizations, Determinations and Notifications	
7.1.2.6.0.2	The CCN may only provider service authorization for abortions in the following situations in accordance with federal and state regulations:	N/A		
7.1.2.6.0.2.1	If the pregnancy is the result of an act of rape or incest; or	Full	Addressed in 08.04 Service Authorization Determination and Notification.	
7.1.2.6.0.2.2	In the case where a woman suffers from a physical disorder, physical	Full	Addressed in 08.04.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed.			
7.1.2.6.0.3	No other abortions, regardless of funding, can be provided as a benefit under the CCN Program.	Full	Addressed in 08.04.	
7.1.2.6.0.4	The CCN UM Program policies and procedures shall include service authorization policies and procedures in accordance with state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:	N/A		
7.1.2.6.0.4.1	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;	Substantial	Substantially addressed in Polciy 08.04 Service Authorization Determination and Notification. Policy needs to be expanded to reflect a member’s request for the provision of a service if a provider refuses the service.	MCO response: Completed. Policy 08.04 has been updated to reflect a member's request for the provision of a service if a provider refuses the service. IPRO response: Determination unchanged. Updated policy will be reviewed as part of next year’s audit.
7.1.2.6.0.4.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Full	Addressed in 08.04.	
7.1.2.6.0.4.3	Requirement that any decision to deny a service authorization	Full	Addressed in 08.04.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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;			
7.1.2.6.0.4.4	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;	Full	Addressed in Member Handbook and grievance policy, includes members' right to issue a complaint about services not rendered.	
7.1.2.6.0.4.5	The CCN's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and non-participating providers; and	Full	HUM system includes ID numbers and service dates.	
7.1.2.6.0.4.6	The CCN's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the CCN regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	Full	Addressed in 08.04. HUM system is electronic.	
7.1.2.6.1	Timing of Service Authorization Decisions	N/A		
7.1.2.6.1.1	Standard Service Authorization - In	Full	Addressed in 08.04.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	regard to standard authorization decisions, the CCN shall provide notice as expeditiously as the enrollee's health condition requires. The CCN shall make eighty percent (80%) of initial standard service authorization 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.			
7.1.2.6.1.1.2	Standard service authorizations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. An extension may be granted for an additional fourteen (14) calendar days if: the member, or the provider, requests extension; or the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's best interest. The CCN shall make concurrent review service authorizations within one (1) business day of obtaining the appropriate medical information that may be required.	Full	Addressed in 08.04.	
7.1.2.6.1.2	Expedited Authorization Decisions - For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously	Full	Addressed in 08.04.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must 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.			
7.1.2.6.1.2.1	The CCN 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 CCN justifies to DHH upon request a need for additional information and how the extension is in the member's best interest.	Full	Addressed in 08.04.	
7.1.2.6.1.3	Post Authorization - Decisions for authorization involving health care services that have been delivered shall be made within thirty (30) calendar days of receipt of the necessary information.	Full	Addressed in 08.04.	
7.1.2.6.2	Notice of Action - The CCN shall notify the member, in writing using language that is easily understood, 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.	Minimal	Policy 08.04 Service Authorization Determination and Notification includes this policy. However, in the onsite review of UM denials cases, five did not include a letter to the member notifying him/her of the right to an appeal or a State Fair Hearing. Also, the communication to the member should include language that services and benefits will continue while the service authorization request is being reviewed. The right to an appeal information was conveyed when services were denied but not when there was a lack of information to evaluate the necessity.	MCO response: Completed. Staff re-directed to send letters to all three parties for denials. Monitoring--Additional audits to be conducted for 90 days targeting this component to ensure compliance. LOI letter revised to include State Fair Hearing Process - pending DHH approval. IPRO response: Determination unchanged. Updated process will be

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			In 2/20 cases, an approval letter was sent to the member when, in fact, a denial letter should have been issued, potentially confusing the member and provider. However, the plan indicated that a system enhancement has been made to automate the notification process, which will eliminate human error. In both cases, no quality of care issues were noted. Both cases concerned denial of service due to a lack of indication of medical necessity. In both cases, a review of the claims log for these members indicated that the tests were not performed.	reviewed as part of next year's audit. File review will be conducted as well.
7.1.2.6.2.1	Approval - For service authorization approval for a nonemergency admission, procedure or service, the CCN shall notify the provider 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. For service authorization approval for extended stay or additional services, the CCN shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.	Substantial	Timeliness standard addressed in 08.04. In 2/20 UM denial cases reviewed, the standard of two weeks to resolve a case was not met. However, subsequent to the date of these determinations, a system upgrade was made to include dates for "waiting for clinicals" to more accurately calculate the date between identification and resolution.	MCO response: Completed. Staff education to select appropriate screen in accord with policy and work flow diagrams. Initiated. Hard-wiring system upgrades to minimize the choices available, based on the type of authorization to minimize human errors. Targeted implementation 1/1/14. IPRO response: Determination unchanged. Updated process will be reviewed as part of next year's audit.
7.1.2.6.2.2	Adverse Determination - The CCN shall notify the member, in writing using language that is easily	Minimal	As described in 7.1.2.6.2 above, 08.04 addresses this policy.	MCO response: Completed. Staff re-directed to send letters to all three parties for

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	understood, 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. The notice of action to members shall be consistent with requirements for member written materials. The CCN shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.		In the review of UM denials, five cases denied because of lack of information did not include a letter to the member notifying him/her of the right to an appeal or a State Fair Hearing.	denials. Monitoring--Additional audits to be conducted for 90 days targeting this component to ensure compliance. LOI letter revised to include State Fair Hearing Process - pending DHH approval. IPRO response: Determination unchanged. Updated process will be reviewed as part of next year's audit.
7.1.2.6.3	Exceptions to Service Authorizations and/or Referrals Requirements	N/A		
7.1.2.6.3.1	The CCN shall not require: service authorization for emergency services or post-stabilization services whether provided by an in network or out-of-network provider; hospital service authorization for nonemergency inpatient admissions for normal newborn deliveries; service authorization or referral for EPSDT screening services; service authorization for family planning services; service authorization for general eye care and vision services; a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal	Full	Addressed in 08.04. All screenings are excluded from prior authorizations.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	care; a PCP referral for access to specialized behavioral health services; service authorization for the continuation of medically necessary State Plan services of a new member transitioning into the CCN, regardless of whether such services are provided by an in network or out-of network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days. The CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.			
7.1.2.6.3.2	The CCN may request to be notified by the provider, but shall not deny claims for payment based solely on lack of notification, for the following: Inpatient emergency admissions within forty-eight (48) hours of admission; obstetrical care (at first visit); and obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	Full	Addressed in 08.04.	
7.1.3	Medical History Information -The CCN is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations. The CCN	Substantial	For all cases reviewed, multiple attempts were made to solicit medical information from providers in cases where such information was needed to render a decision regarding medical necessity. However, there is no evidence that any action was taken by the plan when such information was not forthcoming. If not already in place, the plan may want to consider the use of disincentives in provider contracts to encourage	MCO response: Completed. UM concerns related to obtaining the medical information from providers, necessary to render medical necessity decisions will be included as a standing item for review in PRC and included in Provider profiles.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.		cooperation.	IPRO response: Determination unchanged. Updated process will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.1.4	**PCP Utilization and Quality Profiling**			
7.1.4.1	The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues. The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Substantial	The plan provided PCP profile reports for Q 1, 2, 3 and 4 of 2012 and Q 1 and 2 of 2013. These reports include metrics related to specialist referrals, ED utilization, inpatient stays, lab, radiology, medications and PCP visits. The plan also provided a provider dashboard onsite, which includes readmissions and other metrics for utilization and a quality dashboard that includes adult access, adolescent well visits, comprehensive diabetes care, Chlamydia screening and well child visits for children ages 3, 4, 5 and 6 years. Dashboards were developed with practitioner input and feedback and disseminated in March 2013 as per Quality Improvement Committee (QIC) minutes. The dashboard includes targets and State and national benchmarks. Peer Review Committee minutes of June 6, 2013 reveal presentation of non-compliant providers and discussion. The plan also noted EPSDT practice reports by practice, and Quality Management Committee minutes indicate that the reports were posted on secure website and accessed by 35% of practices. As per the QAPI Program Evaluation, PCP utilization and quality profiles are captured in SQ 072 reports, HEDIS measures and chronic condition reporting. Quality of care issues were noted to be tracked and trended by provider. A review of member grievances revealed that not all member grievances, such as request for change in PCP due to perceived care issues,	MCO response: Initiated. Effective 11/1/13: Provider Dashboards, Utilization data and the Complaint/Grievance reports shall be incorporated into UMC and QIC to identify PCP Utilization and/or Quality of Care Issues as standing reports and minutes shall so reflect identification, investigation and resolution/actions taken. IPRO response: Determination unchanged. Updated process and dashboard will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			were investigated for quality of care. There was some discussion of PCP EPSDT profile reports in quality committee meetings, but follow up was not clear. As per onsite staff, follow up is mostly ad hoc and may not be documented. This follow up may include Medical Director interaction with particular clinicians. Recommendation: The plan should document follow-up of identified utilization or quality of care issues, and ensure member grievances that are potential quality of care concerns are investigated by appropriate staff.	
7.1.4.2	The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall include, but are not limited to, the following: - Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel; - Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel; - Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and - Individual PCP clinical quality performance measures as indicated in Appendix H.	Full	The plan provided quarterly reports as above that include specialist referrals, emergency department utilization, hospital admissions, lab services, medications and radiology services (Reports SQ 072) that were submitted to DHH quarterly. PCP clinical quality performance measures are included in the provider dashboard as noted above. The plan provided provider profiles which include performance measures in Appendix H (Incentive Based Measures and Comprehensive Diabetes Care). The plan provided for review examples of the provider dashboard, which includes quality and utilization measures as in Appendix H. The plan identifies and tracks members' emergency department, access, visits, admissions and readmissions.	
7.1.4.3	PCP Utilization & Quality Profile	Full	The quarterly PCP profile reports and 2012 Annual	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Reporting Requirements- The CCN shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.		Summary were provided for review. Submissions to DHH are tracked in the Shared Savings Report Spreadsheet. Submission for the Annual Summary is documented on 2/28/13.	
7.1.8	**Quality Management**			
7.1.8.0.1	The CCN shall have an ongoing Quality Assessment and Performance Improvement (QAPI) Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. Improvement strategies include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys.	Full	As per the Quality Management Program Description (QM Program Description), the scope of the Quality Management Program provides for objective and systematic evaluation and improvement in quality and appropriateness of care and service provided to members thru measure and analysis of clinical care performance, HEDIS data, service measures for provider and member satisfaction, complaints appeals and fair hearing requests, access and availability of providers, clinical practice guidelines for acute and chronic medical care and behavioral health. Monitoring activities and improvement strategies include provider profiles, medical record audits and monitoring of HEDIS data, surveys and Performance Improvement Projects (PIPs). SQ216, the QAPI Impact and Effectiveness of QAPI Program Evaluation (QAPI Program Evaluation) indicates that for 2012, medical record audits were conducted with 190 records reviewed at 45 practice sites. The QAPI Program Evaluation also notes that the HEDIS Cognizant system was implemented in 4th quarter 2012, allowing for monitoring of gaps in care for HEDIS preventive measures.	
7.1.8.0.2	The CCN shall have mechanisms to	Full	The Utilization Management (UM) Program Description	

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	1) detect underutilization and overutilization of services and 2) assess the quality and appropriateness of care furnished to enrollees with special health care needs.		2013 identifies data analysis of provider practice patterns to identify over and under utilization as an objective; evaluation of this data is the responsibility of the UM Committee. UM meeting minutes of 12/4/12 include discussion of inpatient utilization (length of stay and NICU) as well as Emergency Room (ER) utilization. Utilization data analysis is included in the QAPI Program Evaluation 2013; specifically, inpatient admissions and comparison to LA and national averages, an analysis of length of stay by category, and highest cost inpatient diagnoses are presented. The evaluation indicates that results showing NICU and particularly low birth weight babies to be drivers of utilization; these results have generated a Quality Improvement Project surrounding preventing LBW births. Emergency Department utilization data analysis also appears in the QAPI Program Evaluation. The plan provides chronic care management programs for members with Special Health Care Needs (SHCN). The plan provided reports SQ039 which document identification of members with special health care needs in the context of identifying members for case management; the QAPI Program Evaluation indicates that triggers has been refined with an alternative method of risk stratification. The plan identifies these members through historical claims data, PCP identification and self referral, or identified by the plan. Policy CM01.10 Clinical Assessment and Care Plan Development describes how members are assessed for special needs, care plans developed, and ongoing monitoring for quality of care concerns is conducted. Report SQ042 includes counts of ER visits, admissions for associated diagnoses and complications, and readmissions for members with asthma, CHF, and diabetes and others in case management.	

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			The plan provided reports (SQ042) of members enrolled in chronic care management program with evidence of monitoring of readmissions, ED visits, admissions for members with asthma, CHF, diabetes and other conditions. The plan provided an initial contact report SQ039 regarding identification, assessment and enrollment o f members with potential special health care needs.	
7.1.8.0.3	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.	Full	The QM Program Description describes processes for ongoing monitoring and evaluation. As per the Program Description, an objective of the program is establishing priorities for focused review, with an emphasis on preventive services, high volume providers and high risk services. High risk areas and high volume areas are the focus of ongoing quality initiatives (Well child visits, Emergency Department Utilization, NICU stays, low birth weight and sickle cell disease). The plan provided policies and procedures that outline the use of Clinical Practice Guidelines (P/P CM 01.41) and guidelines for specific conditions such as asthma (Asthma 01.21.03 Asthma Clinical Guideline). The plan provided examples of reports of ongoing monitoring and evaluation, including the QAPI Program Evaluation.	
7.1.8.0.4	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.	Substantial	The QAPI Program Description includes defining and implementing improvement in outcomes and utilization and processes. The plan provided evidence of initiatives in the two Performance Improvement Projects (PIPs) focused on Emergency Department (ED) Utilization and Well Child Visits, and there is reference to additional initiatives focused on sickle cell disease, NICU stays and NICU infection, readmissions for members with behavioral health co morbidity, and low birth weight in committee minutes and to an extent in the QAPI Program Evaluation. Other than the formal PIPs, the initiatives are not well defined and it is not clear what has been implemented. As per onsite interviews, some	MCO response: Initiated. Each of the QIP status reports will be updated to include all current initiatives, before the next respective QIP monthly meeting. Completion date-11/30/13 IPRO response: Determination unchanged. QIP status reports will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			quality initiatives for improving processes, such as coordination with the Behavioral Health Organization around readmissions, are occurring but not documented. Recommendation: The plan should more formally define and document all significant improvement initiatives that are implemented, and track and evaluate success.	
7.1.8.0.5	The CCN shall submit a QAPI Quality Assessment Work plan within thirty (30) days from the date the Contract is signed and annually thereafter, for DHH review and approval.	Full	The plan submitted a 2013 Work Plan that was provided for review.	
7.1.8.0.6	The CCN's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the CCN'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 CCN.	Full	The Quality Management Program Description 2013 outlines this requirement. The Board of Directors, which includes the CEO and owner of CHS and other stakeholders, is identified in the Program Description as governing the organization and establishing broad policies and objectives. The Executive Committee, comprised of the owner and CEO and key executive staff, is identified as ultimately responsible for oversight of the QMP. The Executive Committee sets the mission, goals and strategic direction. The Executive Committee modifies the program to meet the needs and strategic direction of CHS, and provides for implementation of the QMP throughout the organization. The Quality Management Committee (QMC) is the entity accountable for implementation of the QMP, and its activities are summarized and reported to the Executive Committee, which oversees the QMC, for review. As per the QM Program Description, the Executive Committee directs the implementation of the Quality Management Program throughout the organization. Onsite staff provided	

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			examples of how data are shared across the plan to illustrate how all staff contributes to quality.	
7.1.8.0.7	The CCN shall have a process in place to evaluate the impact and effectiveness of its QAPI program. DHH must approve any material change to this plan prior to implementation of the revisions.	Substantial	As per the QM Program Description, the QM Department prepares an annual written evaluation of the QM activities to evaluate the impact and effectiveness of the QMP. The plan provided the QAPI Impact and Effectiveness of QAPI Program Evaluation (QAPI Program Evaluation) for review. Annual reporting to DHH is included in the Work Plan, although DHH approval of any material changes to the plan prior to implementation of revisions is not explicitly noted in documents. Recommendation: The plan should note the required approval of DHH for material changes to the plan in policies and procedures.	MCO response: Completed. The state SQ216 report was submitted, but was absent documentation of DHH approval prior to implementation. In anticipation of the Annual submittal (for 2014), the template for the QM Program description has been updated to include documentation of DHH approval. IPRO response: Determination unchanged. Updated Program Description will be reviewed as part of next year's audit.
7.1.8.1	QAPI Committee	N/A		
7.1.8.1.1	The CCN shall form a QAPI Committee.	Full	The QMP Program Description identifies the Executive Committee as responsible for oversight of the Quality Management Program (QMP), with day to day management of the QMP delegated to the Quality Management Committee (QMC). The QMC is comprised of the management of all departments and functional areas of the organization. This Committee is identified as Corporate in the QM Program Description and the Quality Improvement Committee (QIC) is identified in the QM Program Description as a program-specific committee. There is some overlap of responsibilities between the two committees, but as per the QAPI Program Description, the QMC oversees the Quality Management Program and the QIC oversees the Quality Management Program for the designated program. As per the Program Description, the QIC monitors implementation and compliance of the program specific requirements.	

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State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			As per the QAPI Program Evaluation, the committee structure was to be changed to reflect a state-specific QIC. This appears to have taken place in June 2013 as per submitted minutes for meeting held 6/7/13. There was also a meeting in June of the QMC-LA Committee, which is not described in the Program Description. Recommendation: The plan should clarify QMC-LA and QIC Committees in the Program Description as applicable.	
7.1.8.1.2	The CCN Medical Director must serve as either the chairman or co-chairman.	Substantial	The QM Program Description identifies the Vice President of Quality Management as the Chair of the QMC and the Program Chief Medical Officer as the chairman of the QIC. It does appear from minutes that the plan's Medical Director does chair the QMC-LA meetings. Recommendation: The plan should clarify the relationship of the QMC, QMC-LA and QIC in the Program Description as noted above and ensure that the plan's Medical Director chairs or co-chairs the plan's QAPI committee.	MCO response: Completed. Although the QM Program description listed the CMO as co-chair of the QMC and chair of the QIC, tasked with the responsibility of ensuring implementation and monitoring of the CHS-LA QM Plan. To reduce confusion of the committees (with similar names), a committee structure diagram has been added to the QM Plan. QMC is corporate level committee, while QIC is the committee responsible for the CHS-LA QAPI function. IPRO response: Determination unchanged. Updated QM plan and process will be reviewed as part of next year's audit.
7.1.8.1.3	Appropriate CCN staff representing the various departments of the organization will have membership on the committee.	Full	As per the QM Program Description, staff on the QMC include, in addition to the VP of Quality Management and the program Chief Medical Officer, the Compliance Officer, Executive VP of Marketing/Quality Management; Executive VP of Government Programs/Operations, Chief Information Officer or Is designee, Senior VP of Care Management, Director of Human Resources, Quality Program Manager/Grievance System Coordinator; Managers of Member Services and Claims Services and Member National Processing Center and an ad hoc Member	

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State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Advocate. QIC representatives include the Chief Medical Officer (Chair), Quality Program Manager, Clinical Managers, Care Management/Utilization Management Supervisors, Grievance System Coordinator, Managers of Member Services, Manager of Claims Services, and ad hoc Member Advocate, network provider and human resources members. Minutes reveal active participation of representatives of various departments.	
7.1.8.1.4	The CCN is encouraged to include a member advocate representative on the QAPI Committee.	Full	The QMC and QIC include an ad hoc member advocate as per the QM Program Description.	
7.1.8.1.5	The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include: direct and review quality improvement (QI) activities; assure that QAPI activities take place throughout the CCN; review and suggest new and/or improved QI activities; direct task forces/committees to review areas of concern in the provision of healthcare services to members; designate evaluation and study design procedures; conduct individual PCP and practice quality performance measure profiling; report findings to appropriate executive authority, staff, and departments within the CCN; direct and analyze periodic reviews of members' service utilization patterns; and maintain minutes of all committee and sub-committee meetings; submit meeting minutes to DHH within 5 working days of the	Substantial	The QM Program Description indicates that the QMC and QIC meet quarterly. Agendas were provided for the QMC for 3/30/12, 6/20/12, 9/27/12, 12/2012, but minutes of meetings were only provided for July 2012, December 2012, 1/28/13 (QMC-LA) and June 2013 (QMC-LA). As per the Program Evaluation, QMC minutes for 3/30/12, 6/20/12, 12/27/12 and 1/28/13 were submitted to DHH. QIC minutes were provided for a meeting on 6/7/13. Minutes include discussion of the QM Work Plan and a review of grievances, Early Warning Measures, EPSDT, provider profiling, provider dashboard. The QMC reviewed the Program Evaluation which includes baseline Level 1 measures and utilization metrics. As per the QAPI Program Description, the committee communicates findings and recommendations to appropriate departments. There is little detail of planned improvement activities in committee minutes except for discussion of CAPS	MCO response: Completed. Effective June 2013, QIC and QMC have met quarterly, and shall continue to do so. IPRO response: Determination unchanged. Updated process will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	meetings; report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services. Ensure that a QAPI committee designee attends DHH's quality meetings.		until the June 2013 QMC-LA and QIC committees regarding initiatives to address identified issues, such as outreach to members with infants in NICU for case management and working with Magellan to address members with readmission and behavioral health co morbidity. These initiatives do not appear in the 2013 Work Plan, and as per onsite staff there may be some quality improvement activities that are not documented, such as interaction with network providers by the Medical Director. There is no documentation of task forces/committees addressing areas of concern. There is documentation of provider profiling and PIPs in committee, as well as utilization. The QAPI Program Evaluation reviewed by committee does include care management services. As per onsite staff, the Medical Director is the designated attendee of DHH's quality meetings. The reporting schedule for minutes is included on the reports of committee minutes. Recommendations: The plan should ensure that the plan's QAPI committee meets quarterly. The plan should ensure that the plan's QAPI Committee conducts continuous quality improvement by identifying actions and interventions for identified issues ("review and suggest new and/or improved QI activities"), and that these initiatives are documented in Work Plans.	
7.1.8.2	QAPI Plan - The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic division provided by the governing body. The QAPI plan shall be submitted to DHH for written approval within	Full	The QMC and QIC responsible for reviewing, revising and approving the QAPI Program Description and Work plan (written program and supporting work plan). The QM Program Description includes goals and objectives as reviewed by the Executive Committee. Annual submission of the written QAPI Program Description and supporting Work Plan to DHH are included in the	

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	thirty (30) date the Contract is signed, annually thereafter, and prior to revisions. The QAPI plan shall:		Work Plan. As per the QM Program Description, the written plan is in addition to policies and procedures to implement the organization-wide Quality Management Program.	
7.1.8.2.0.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	Full	The QM Program Description includes this language regarding a coordinated strategy to implement the program.	
7.1.8.2.0.2	Include a description of the CCN staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	Substantial	The QM Program Description outlines roles and responsibilities of senior management staff including the Chief Executive Officer, President of CHS, Chief Medical Officer, President and COO of Premier Administrative Solutions, Chief Information Officer, VP of Clinical and Quality Operations/Compliance, Manager of Quality Management, Executive Director of Government Programs, Managers of Care Management, Human Resources and Member/Provider Services and Medical Directors. Organization of staff was provided in the O.D.1 CHS-LA Organizational Chart. In this chart, there is a plan position described as Quality Management Coordinator & Performance/Quality Improvement Coordinator. This position is not described in the QM Program Description. It is not clear if this is the same position as the Manager of Quality Management (the Coordinator reports to the Grievance Systems Manager and the Manager of QM is described as reporting to the VP of Clinical and Quality Operations. Other positions on the Organizational Chart reporting to the QM Coordinator do not appear in the QM Program Description, such as the HEDIS Coordinator and Quality Support. The QM Program Description indicates that data systems are driven by a team of programmers and analysts. Quality Management program training is	MCO response: Completed. Effective June 2013, QIC and QMC have met quarterly, and shall continue to do so. IPRO response: Determination unchanged. Updated process will be reviewed as part of next year's audit.

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State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			provided to newly hired staff. Specific training and background is discussed for staff involved in Utilization Management and care management activities in UM Policies: UM08.03 Clinical Review, UM 02.23 Senior Clinical Staff and UM02.07 (appeal reviewer qualifications). Recommendation: The plan should ensure that a description of all plan staff assigned to the QAPI Program, including training and responsibilities, appear in the written QAPI plan.	
7.1.8.2.0.3	Describe the role of its providers in giving input to the QAPI Program.	Full	As per the QM Program Description, provider input in sought as part of the QM strategy. As per the QM Program Description, there is opportunity for network provider input to the QM program through the program-specific Provider Advisory Committee (PAC). The role of the committee is described in the QM Program Description, and members include 7 provider's representative of the populations served by the plan and other ad hoc representatives as appropriate. The Committee meets at least semi-annually as per the Program Description. PAC minutes were not provided for review, but PAC committee minutes were reviewed at the QIC meeting of 6/7/13. As per the 6/7/13 QIC minutes the PAC met 3/28 and discussed the dashboard, emergency department visits and credentialing. There is also a review of PAC activity in the minutes of the QMC-LA meeting of 1/28/13. As per the Program Description, network providers also serve on the ad hoc Peer Review Committee and Credentialing Committee. There is to be an ad hoc network provider on the QIC as per the QM Program Description, and the QMC for LA minutes of June of 2013 indicate that recruiting network providers for the QIC is an action item. Providers are encouraged to provide input as per the	

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			QM Program Description. As per P/P CM 01.41 Clinical Practice Guidelines, guidelines are adopted in consultation with network providers. As per onsite staff, the Medical Director routinely interacts with network providers.	
7.1.8.2.1	QAPI Reporting Requirements - The CCN shall submit QAPI reports annually to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports. The QAPI reports shall contain at a minimum:	Full	The plan provided INT08.09 CHS-LA DHH reporting, which outlines processes for tracking and submitting DHH required reports. The QM Work Plan documents reporting timeframes for QAPI reports. The plan submitted all reports as required during the review period.	MCO response: Initiated. In conjunction with the Annual Review and updating of the QM Plan, the documentation will be updated to include all current PIP/QIPs and outcomes by 1/1/14. IPRO response: Determination unchanged. Updated documents will be reviewed as part of next year's audit.
7.1.8.2.1.0.1	Quality improvement (QI) activities;	Substantial	Quality Improvement Projects are described in the QM Program Description. Although the QM Work Plan and Program Evaluation document monitoring and evaluation of utilization and quality data, there is limited documentation of initiated QI activities, status of activities or follow up of findings. For example, low birth weight was identified as an issue in the Program Evaluation and it is indicated that a QIP has been established; however, other than further analysis, management of this issue is documented in the Work Plan as "create improvement strategy and deploy" without further detail. Sickle cell disease as a driver of readmission is also identified in the Program Evaluation but does not appear in the Work Plan, and an action plan indicated to improve PCMH recognition rates is not described. The Program Evaluation does indicate that triggering for case management was modified based on findings. As per onsite discussion, there appears to be quality improvement activity underway that is not reflected in the Work Plan. Some of this activity can be identified in committee minutes and PIP	MCO response: Initiated. In conjunction with the Annual Review and updating of the QM Plan, the documentation will be updated to include all current PIP/QIPs and outcomes relating to initiatives by 1/1/14. IPRO response: Determination unchanged. Updated documents will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			status reports. Recommendation: The plan should ensure that quality improvement activities and status updates are documented in Work Plans.	
7.1.8.2.1.0.2	Recommended new and/or improved QI activities; and	Minimal	As noted above, there is limited documentation in reports of initiated QI activities, status of activities or follow up of findings with modification of activities in the Work Plan or documents other than PIP reports. Recommendation: The plan should ensure that quality improvement activities and activity status updates are documented in Work Plans, and new activities or modification to existing activities are recommended based on evaluation findings.	MCO response: Initiated. In conjunction with the Annual Review and updating of the QM Plan, the documentation will be updated to include all current PIP/QIPs and outcomes relating to initiatives by 1/1/14. IPRO response: Determination unchanged. Updated documents will be reviewed as part of next year's audit.
7.1.8.2.1.0.3	Evaluation of the impact and effectiveness of the QAPI program.	Substantial	As per the Program Description, the QMC prepares an evaluation of the QMP and presents outcomes and conclusions to the Executive Committee annually or as directed by the Executive Committee. The plan submitted the QAPI Impact and Effectiveness of QAPI Program Evaluation (QAPI Program Evaluation) for review. This Evaluation was reviewed by the QMC. The Evaluation does not include an overall assessment of strengths and opportunities for improvement or detail of barrier analysis and assessment of opportunities for improvement of some elements in the Evaluation such as chronic care management and level 1 performance measures. Recommendation: The plan should ensure that an evaluation of the impact and effectiveness of the QAPI program includes an assessment of whether there is opportunity for improvement of each area evaluated, potential barriers and actions to be implemented for areas in need of improvement.	MCO response: Initiated. In conjunction with the Annual Review and updating of the QM Plan, the documentation will be updated to include all current PIP/QIPs and outcomes by 1/1/14. IPRO response: Determination unchanged. Updated documents will be reviewed as part of next year's audit.
7.1.8.3	The CCN shall participate in the	Full	As per interviews with onsite staff, the Medical Director	

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	Department's quality committee.		and Quality Manager participate in the Department's quality committee. Recommendation: The plan should include this requirement in policies/procedures or program description.	
7.1.8.4	The CCN will agree to an External Quality Review, review of the Quality Assessment Committee meeting minutes, and annual medical audits to ensure that CCN providers provide quality and accessible health care to CCN members, in accordance with standards contained in this RFP and under the terms of this RFP. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to surveys and other information concerning the use of services and the reasons for member disenrollment.	Full	The plan participated in the EQR and provided documentation necessary and made staff available for the review. A crosswalk of documents to contract elements that was requested was provided onsite. Recommendation: The plan should consider including EQR and other audits in work plans or program description.	
7.1.8.5	It is agreed that the standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to DHH prior approval.	Full	The plan provided an example of a Corrective Action Plan for Case Management that was submitted to DHH in 2012 using the plan's Quality Management Corrective Action Plan Documentation Form. The CAP form includes a description of the issue, reason for non-compliance, and actions and interventions to improve. Responsible parties and timeline for due dates and completion dates as well as outcome are included in the form. The plan's CAPs are included in the Work Plan and QAPI Program Evaluation, and corrective action plans are addressed in the QM Program Description.	
7.1.8.6	In the event the CCN fails to	N/A		

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	complete the actions required by the CAP, the CCN agrees that DHH may assess the monetary penalties specified in this RFP. The CCN further agrees that any monetary penalties assessed by DHH will be due and payable to DHH immediately upon notice. If payment is not made by the due date, said monetary penalties may be withheld from future enhanced primary care case management fee payments by DHH without further notice.			
7.1.8.7	The CCN is required to conduct performance improvement projects as specified in this RFP.	Full	The plan conducted and submitted two Performance Improvement Projects in the review period, Well Child Visits at 15 months and Emergency Department Utilization. As per onsite, the plan also conducted quality improvement projects related to low birth weight, NICU, and readmissions for members with sickle cell disease.	
7.1.9	**Performance Measures**			
7.1.9.1	The CCN shall report clinical and administrative performance measure (PM) data, as specified by DHH and in accordance with the specifications of the CCN Quality Companion Guide.	Full	The plan reported administrative performance measure data as required by DHH and also reported clinical performance data. The measure results are included in the QAPI Program Evaluation. Performance measures are reported in the QAPI Program Evaluation.	
7.1.9.2	The CCN is required to report on PMs listed in Appendix H which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures,	Full	The plan reported Administrative measures and Level 1 HEDIS measures as per Appendix H, and these measures are included in the Program Evaluation.	

Enhanced Primary Care Case Management (PCCM)				
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	Consume Assessment of Healthcare Providers and Systems (CAHPS) measures, and/or other measures as determined by DHH.			
7.1.9.3	The CCN shall have processes in place to monitor and self-report all performance measures.	Full	The plan provided evidence of monitoring and reporting performance measures in Work Plans and the QAPI Program Evaluation, and provided.	
7.1.9.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	N/A	Clinical performance measures are included in the QAPI Program Evaluation.	
7.1.9.5	Administrative PMs shall be submitted to DHH semiannually and upon DHH request.	Full	The plan provided reports of Administrative PMs SQ 217 and these are included in the QAPI Program Evaluation.	
7.1.9.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	N/A	The plan has collected baseline rates only for clinical performance measures.	
7.1.10	**Early Warning System Performance Measures**			
7.1.10.0	The CCN shall collect and report monthly on the Early Warning System Performance Measure outcomes, as specified by DHH in this RFP (Appendix H), in order to monitor and evaluate the successful implementation of the CCN program. During a CCN's first two years of operations, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" performance measures and compliance under this Contract. After the second year of operations, distribution of any	Full	The plan provided copies of monthly report SQ217 Early Warning System Performance Measures for 2012 and 2013. The Early Warning reports are discussed in QMC minutes.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	savings will be contingent upon the CCN meeting established performance measures and compliance with this Contract.			
7.1.11	**Incentive-based Measures**			
7.1.11.1	Incentive Based (IB) measures are Level I measures that may affect savings payments and can be identified in Appendix H with "$".	N/A	The plan discussed Incentive Based measures in the QIC meeting of 6/7/13. These measures were reported by the plan in 2013.	
7.1.11.2	A maximum of 100% eligible (20% for each of the 5 Incentive Based Performance Measures) savings payout will be contingent upon the CCN's Performance Measure outcomes for CYE 12/31/2013 or otherwise specified by DHH. All Incentive Based and Level I performance measures that fall below performance standards will require a corrective action plan (CAP) (See Appendix H).	N/A		
7.1.11.3	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide sixty (60) days notice of such change.	N/A		
7.1.12	**Reporting Measures**			
7.1.12.1	All Administrative, Level I and Level II PMs are reporting measures.	N/A	The plan reported Administrative, Level I HEDIS measures, and is planning Level II reporting for 2014.	

Enhanced Primary Care Case Management (PCCM)				
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			Recommendation: The plan should consider including required performance measure reporting in the QAPI Program Description.	
7.1.12.2	Administrative measure reporting is required semiannually and upon DHH request.	Full	The plan provided reports of Administrative PMs SQ 217 and these are included in the QAPI Program Evaluation.	
7.1.12.3	Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.	N/A	The plan includes PQI measures in the 2013 Work Plan; results for PQI measures were not included in the QAPI Program Evaluation.	
7.1.12.4	Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.	N/A	The plan includes PQI measures within Level I in the 2013 Work Plan.	
7.1.12.5	Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.	N/A	The plan reported Administrative PMs and Level I HEDIS measures are included in the Program Evaluation as noted above.	
7.1.12.6	Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2012 data for Contracts that begin after January 1, 2012.	N/A	The plan reported Level I HEDIS measures and has Level I and Level II reporting included in the QM Work Plan and Program Evaluation.	
7.1.12.7	DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.	N/A		

Enhanced Primary Care Case Management (PCCM)				
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7.1.13	**Performance Measure Goals**			
7.1.13.1	The Department will establish benchmarks for Incentive Based and Level I Performance measures utilizing statewide data of the Medicaid Fee for Service Population for CY 2011 with the expectation that performance improves by a certain percentage.	N/A		
7.1.13.2	Statewide goals will be set for 2015 Level II Performance Measures utilizing an average of all CCNs'outcomes received in 2014 for the 2013 measurement year.	N/A		
7.1.14	**Performance Measure Reporting**			
7.1.14.1	The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Full	Data sources for monitoring are documented in the QM Program Description and further described in the QAPI Program Evaluation. The plan provided evidence of automated monitoring systems in provider profile reports, provider dashboards, EPSDT reports, utilization reports, chronic care management reports and results reported in the Program Evaluation.	
7.1.14.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.	Full	As per the QM Program Description indicators can be designed and as per onsite staff reports can be modified.	
7.1.14.3	The CCN shall have processes in place to monitor and self-report performance measures as specified in §16, Reporting Measures using DHH specified requirements and format. The CCN shall provide individual PCP clinical quality profile	Full	The QAPI Program Evaluation provides evidence of reporting measure monitoring and the plan provided PCP quality profile reports for review as noted above.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	reports as indicated specified by DHH.			
7.1.15	**Performance Measure Monitoring**			
7.1.15.1	DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.	N/A		
7.1.15.2	During the Contract, DHH or its designee will actively participate with the CCN to review the results of performance measures.	N/A		
7.1.15.3	The CCN shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to CCN members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.	Full	The plan complied with the EQR by providing documentation, files and making staff accessible for interview as needed.	
7.1.15.4	The standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP)	N/A	EQR findings have not yet been communicated to the plan.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to approval by DHH. DHH will monitor the CCN's progress in correcting the deficiencies.			
7.1.16	**Corrective Action Plan**			
7.1.16.0	A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.	N/A		
7.1.16.1	The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the violation or noncompliance specified by DHH.	Substantial	CAPS are included in the QAPI Program Evaluation and QM Work Plans. The plan provided Quality Management Corrective Action Plan Documentation Forms for review (UM Turn Around Time). Timeframes for CAPs submissions are not included in submitted P/P or Program Descriptions. Recommendation: The plan should include required timeframes for CAPs in P/P or Program Description.	MCO response: Initiated. In conjunction with the Annual Review and updating of the QM Plan, the documentation will be updated to include CAP submissions, status and outcomes by 1/1/14. IPRO response: Determination unchanged. Updated documents will be reviewed as part of next year's audit.
7.1.16.2	Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the CCN shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the concerns identified by DHH.	N/A		
7.1.16.3	Upon approval of the CAP, whether the initial CAP or the revised CAP, the CCN shall implement the CAP	Full	The reviewed Corrective Action Plan Documentation Form included approved timeframes and outcomes.	

Enhanced Primary Care Case Management (PCCM)				
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	within the time frames specified by DHH.			
7.1.16.4	DHH may impose monetary penalties, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	N/A		
7.1.17	**Performance Improvement Projects**			
7.1.17.1	The CCN shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures.	Full	Quality Improvement Projects are addressed in the QM Program Description. The plan conducted two Performance Improvement PIPs approved by DHH, and is conducting internal PIPs addressing NICU low birth weight, infection rates in NICUs, and readmissions and sickle disease as per onsite staff and committee minutes.	
7.1.17.2	The CCN shall perform a minimum of two (2) DHH approved PIPs in the first Contract year. The DHH required PIP during the first Contract year is listed in Section 1 of Appendix V - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of Appendix V. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.	Full	The plan implemented two Performance Improvement Projects as listed in Appendix V, Well Child Visits 0 to 15 Months and Emergency Department Utilization.	
7.1.17.3	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 PIP must involve the following:	Full	The plan implemented two PIPs and reports were reviewed; both included ongoing measurement and interventions that are expected to achieve improvement. Each PIP incorporates objective measures, system interventions including case management for frequent ED users and children with gaps in care. Each PIP includes evaluation of results and next steps for improvement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	a. Measurement of performance using objective quality indicators; b. Implementation of system interventions to achieve improvement in quality; c. Evaluation of the effectiveness of the interventions; and d. Planning and initiation of activities for increasing or sustaining improvement.			
7.1.17.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the CCN shall submit, in writing, a general and a detailed description of each PIP to DHH for approval. The detailed PIP description shall include: a. An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers; b. The study question; c. The study population; d. The quantifiable measures to be used, including a goal or benchmark; e. Baseline methodology; f. Data sources; g. Data collection methodology and plan; h. Data collection cycle; i. Data analysis cycle and plan; j. Results with quantifiable measures; k. Analysis with time period and the measures covered;	Full	The plan submitted detailed PIP proposals and status reports for the two implemented PIPs. The proposals included PIP topic and rationale and study questions, and the study population is identified. The plan identified reaching NCQA 50th percentile in the aim for both PIPs. Methodology, data sources and data collection processes are included in each PIP. Results are reported with analysis of results and next steps. EQRO review comments noted that process measures are desirable and would enhance the ability to analyze opportunities for improvement and need to modify interventions; some process measures are included in the ED PIP.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	l. Analysis and identification of opportunities for improvement; and m. An explanation of all interventions to be taken.			
7.1.17.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts) for monitoring and shall: a. Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; b. Use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions; c. Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; d. Implement system interventions to achieve improvement in quality; e. Evaluate the effectiveness of the interventions; f. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; g. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; h. Reflect the population served in terms of age groups, disease	Substantial	PIPs included tabular and graphic representation of monitoring, targeted Emergency Department Utilization and Well Child Visits 0-15 months for system wide monitoring and the ED PIP includes individual practitioner monitoring. PIPs address recommended well child visits and emergency department utilization that could potentially be avoided. Each PIP includes HEDIS measures based on appropriate well child visits and rates of ED utilization; EQRO review noted that site specific rates of ED utilization could facilitate interpretation of results and focus interventions. Additional process measures are also recommended to enhance interpretation of effectiveness of interventions for Well Child Visits. System interventions are implemented. The Well Child Visit PIP includes analysis of visits by race/ethnicity and geographic distribution, and reflects the plan's population, which is primarily children. The ED PIP includes all members. PIPs are reviewed in QMC and QIC meetings as per minutes, and the QMC and QIC include health professionals and multidisciplinary teams. This is consistent with the QAPI Program Description. Procedures for data extraction are detailed in each PIP report. EQRO review noted that suspension of enrollment criteria for the Well Child PIP could limit interpretation of results. Data are tracked over time, but EQRO review noted that for the Well Child Visit PIP the plan could consider tracking administrative data on a monthly rolling basis to track progress more frequently. Recommendation: The plan should include process measures for the Well Child PIP and consider tracking progress through administrative data more frequently	MCO response: Initiated. Each of the QIP status reports will be updated to include more specific outcomes, before the next respective QIP monthly meeting. Completion date-11/30/13 IPRO response: Determination unchanged. Updated status reports will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	categories, and special risk status, i. Ensure that appropriate health professionals analyze data; j. Ensure that multi-disciplinary teams will address system issues; k. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; l. 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 m. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.		than annually.	
7.1.17.6	DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The CCN shall report the status and results of each PIP as specified in the Quality Companion Guide. a. If CMS specifies Performance Improvement Projects, the CCN will participate and this will count toward the State-approved PIPs.	Full	The plan reported on the status and baseline results of the two implemented PIPs.	
7.1.17.7	Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the	Full	The plan's PIP reports include timelines with reporting of results (baseline, interim, and remeasurement) annually.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.			
7.1.18	**PIP Reporting Requirements**			
7.1.18.1	The CCN shall submit PIP outcomes annually to DHH.	Full	The plan submitted PIP status reports for the two implemented PIPs as required.	
7.1.18.2	Reporting specifications are detailed in the Quality Companion Guide.	Full	The plan submitted the reports as specified.	
7.1.18.3	DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports.	N/A		
7.1.19	**Member Advisory Council**			
7.1.19.0	The CCN 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. The Council is to be chaired by the CCN's Administrator / CEO / COO or designee and will meet at least quarterly. Every effort shall be made to include a broad representation of both members / families / significant others,	Substantial	The plan submitted the Member Advisory Council Plan 2013, which describes the Member Advisory Council. The plan provided a roster of MAC members as of August 28, 2013. The roster includes representatives of the Multiple Sclerosis Society, Family and Youth Counseling Agency, Acadiana Breastfeeding Coalition, Children's Coalition, Caring Clinic of LA, and March of Dimes. The Member Advisory Council Plan includes the description that at least 50% of the membership is comprised of members, families and member advocacy groups. The MAC meets quarterly as per the QAPI Program Description. The MAC met on 1/23/13 as per submitted minutes, at which time members were still being recruited; this was the first meeting as per the Member Advisory Council Plan. There is a second set of	MCO response: Completed. Contract requirement requires membership to the MAC to consist of at least 50% Member advocacy Groups. Minutes demonstrated compliance in 2013. No corrective action possible for 2012 deficiency. IPRO response: Determination unchanged. Updated process and minutes to assess whether the MAC was held quarterly as per state requirements will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	member advocacy groups and providers that reflect the population and community served. Members / families / significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.		minutes for quarter 2 2013 that are also dated 1/23/13. Three of the member advocates from the membership roster attended the Q1 meeting and two attended the Q2 meeting. Minutes were submitted for Quarter 1 2012, but it appears to be a planning meeting and there do not appear to members, and outreach to potential members is discussed. The MAC is chaired by the Quality Program Manager/Grievance Coordinator as per the plan. Recommendation: The plan should ensure that the MAC meets at least quarterly and continue to ensure member attendance.	
7.1.19.1	The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Full	Training for MAC members is outlined in the Member Advisory Council Plan and responsibilities are listed. A letter to an MAC member was provided by the plan that included an overview of the Council and member responsibilities.	
7.1.19.2	The CCN 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 not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the contract and annually thereafter by December 15h.	Full	The Member Advisory Council Plan outlines the goals of the council including soliciting members' perspectives and documents that the MAC will meet quarterly. Submission of the plan to DHH by December 15 is included in the Member Advisory Council Plan document.	
7.1.19.3	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.	Full	The Member Advisory Council Plan includes the requirement that DHH is included in all correspondence and agenda and minutes are posted on the plan's website.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.19.4	A representative of the Member Advisory Council shall participate on the DHH CCN Member Advisory Committee.	Full	It is documented in the Member Advisory Council Plan that there is participation of a representative on the DHH-CHSLA MAC.	
7.1.20	**Member Satisfaction Surveys**			
7.1.20.1	The CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and utilize methodology to assess the quality and appropriateness of care to members.	Full	CAHPS reports were submitted June 2013 and include adult and child reports, including the children with chronic condition module.	
7.1.20.2	The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. a. The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.	Full	The plan's CAHPS vendor was Data stat, an NCQA certified CAHPS vendor. The plan's vendor conducted the CAHPS Adult survey, Child survey and Children with Chronic Conditions survey.	
7.1.20.3	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	Full	The survey process and survey results are included in each CAHPS survey report and the QM Work Plan documents reporting to DHH.	
7.1.20.4	The CAHPS survey results shall be reported separately for each CCN GSA. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the CCN at the time of the survey.	Full	Separate GSA reporting was not required. The surveys were administered. A random sample was generated from the plan population for statistically valid samples and response rates were 24.8% for children and 19.5% for adults.	
7.1.20.5	The surveys shall provide valid and reliable data for results in the specific CCN GSA.	N/A	GSA reporting not required.	

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State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.20.6	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	Minimal	The CAHPS reports provided do not include comparison to national and state benchmark data. "Achievements" are identified as desirable satisfaction percentages.	MCO response: Initiated. While CAHPS 3 Point Ratings Report was available for comparison of CHS LA to NCQA Ratings, statistical analysis and improvement efforts will be documented in the Work Plan. Target date 12/1/13. IPRO response: Determination unchanged. Updated CAHPS findings will be reviewed as part of next year's audit.
7.1.20.7	The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include: a. Getting Needed Care b. Getting Care Quickly c. How Well Doctors Communicate d. Health Plan Customer Service e. Global Ratings	Full	CAHPS 5.0 Child and Adult were conducted and included the listed requirements.	
7.1.20.8	Member Satisfaction Survey Reports are due one hundred and twenty (120) days after the end of the plan year.	Full	CAHPS reports were submitted in June of 2013.	
7.1.21	**Provider Satisfaction Surveys**			
7.1.21.1	The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims preprocessing, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.	Substantial	As per SI133 the CHS Provider Satisfaction Survey Report, the plan conducted a provider satisfaction survey beginning in January 2013 but had difficulty with results due to low rates of response to items after the first page, rendering interpretation of results difficult. In addition, response rates were low overall. The survey addressed enrollment, education, communication, complaints claims preprocessing, utilization management and Patient Centered Medical Home implementation support. The plan intends to automate the survey to improve data collection.	MCO response: Completed. Adequate documentation in place during review to evidence conducting the annual provider survey. Provider Satisfaction Surveys are completed per contract requirement. Initiated. An internal CAP has been put in place by CHS to pursue opportunities to improve survey response rate.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Recommendation: The plan should implement improvement initiatives for data collection as planned to facilitate retrieval of interpretable results.	IPRO response: Determination unchanged. The 2014 survey results will be reviewed as part of next year's audit.
7.1.21.1.1	The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	Full	As per the Provider Satisfaction report, the tool and methodology were submitted to DHH for approval and modified with DHH input.	
7.1.21.2	The CCN shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one-hundred and twenty (120) days after the end of the contract year.	Full	SI133 CHS Provider Satisfaction Survey Report was submitted April 30, 2013 that summarizes methodology, findings and analysis.	
7.1.22	**DHH Oversight of Quality**			
7.1.22.0	DHH shall evaluate the CCN's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified by the Contract. If DHH determines that the CCN's quality performance is not acceptable, DHH will require the CCN to submit a corrective action plan (CAP) for each unacceptable performance measure. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and	N/A		

Enhanced Primary Care Case Management (PCCM)				
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	automatic assignments. Upon any indication that the CCN's quality performance is not acceptable, DHH may restrict the CCN‘s enrollment activities including, but not limited to, termination of automatic assignments. When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the CCN‘s cumulative performance on all quality improvement activities. The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.			
7.1.22.1	External Independent Review	N/A		
7.1.22.1.1	The CCN shall provide all information requested by the External Quality Review Organization (EQRO) and/or DHH including, but not limited to, quality outcomes concerning timeliness of, and member access to, core benefits and services.	Full	The plan provided information requested by the EQRO including PIP reports and revisions and documents required for the annual review.	
7.1.22.1.2	The CCN shall cooperate with the EQRO during the review (including medical record review, which will be done at least one (1) time per year.	Full	The plan cooperated with the EQRO during review and provided documents, files and made staff available as needed. The crosswalk of documents to contract requirements was provided onsite.	

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7.1.22.1.3	If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN and may immediately terminate all enrollment activities and automatic assignment until the CCN attains a satisfactory level of quality of care as determined by the EQRO.	N/A		
7.1.22.1.4	A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the Contractor's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQR.	N/A	EQR findings were not yet submitted to the plan. Recommendation: The plan should include response to EQR findings in the QM Program Description or Work Plan.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
	Credentialing and Re-credentialing of Providers and Clinical Staff			
	The CCN must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 and NCQA health plan Accreditation Standards for the review and 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.	Substantial	CRE 08.01 Credentialing & Re-credentialing Process submitted for review Though DHH does not require credentialing, CHS elected to conduct credentialing of providers. IPRO reviewed credentialing files and policies and procedures for this assessment. Provider's credentialing application is received in the Florida office and reviewed for completeness. NPI numbers and USPS address and confirm license is active. If information is present and it is a routine file, the application is sent to the Medical Direction for approval. If the application is considered non-routine, the Medical Direction forwards to the peer review committee for review. Providers are activated 1 month after primary source review and the completion of the credentialing process. Date of receipt of application: received electronically from LA office, given a task assignment and initial review is done. Upon determination that the application is "clean" it is returned to the LA office. CHS stated they intend to seek NCQA Accreditation in the future and was advised to follow the NCQA process in future credentialing decisions. The dates are important for this process. During file review, gaps were identified in: 1. Date of receipt of application - Credentialing process initiated 1/1/2013	MCO response: Completed. Policies have been updated to ensure documentation of dates of: receipt of application, review decision, written notification of decision and initial site visit. IPRO response: Determination unchanged. Updated policies will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			2. Date of review decision 3. Date of written notification of decision – implemented notification process 9/1/2013 4. Initial site visit date	
	The CCN shall use the state's standardized credentialing form (see Appendix F – Louisiana Standardized Credentialing Application Form).	Full	File review showed that applications were submitted on the Louisiana Standardized Credentialing Application Form or the CAQH form Conflict: Provider Handbook requests that providers use the CAQH application whenever possible	
	An independent relationship exists when the CCN selects and directs it members to see a specific provider or group of providers.	N/A	DHH does not require credentialing at this time	
	These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.	N/A		
	The process for periodic re-credentialing shall be implemented at least once every three (3) years.	Full	PCCM.D.19.a 03 Delegated Credentialing P&P shows compliance with this standard	
	If the CCN is not NCQA health plan accredited and has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The CCN must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with DHH's credentialing requirements. DHH will have final approval of the	Full	PCCM.D.19.a 03 Delegated Credentialing P&P shows compliance with this standard CHS is URAC Accredited (evidence submitted) but not NCQA Accredited. CHS plans to pursue NCQA Accreditation in the future.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	delegated entity.			
	If the CCN has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	N/A	CHS is URAC Accredited (evidence submitted) but not NCQA Accredited. CHS plans to pursue NCQA Accreditation in the future. DHH does not require credentialing at this time.	
	The CCN 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.	Full	PCCM.D.18.a CRE 08.01 Credentialing and Re-Credentialing Process Version 4 shows process to approve new providers PCCM.D.21 CRE08.04 Provider Terminations Version 2 shows process to terminate providers upon request from provider	
	The CCN shall develop and implement a mechanism, with DHH's 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.	Minimal	PCCM.D.21 CRE 08.04 Provider Termination Version 2 outlines termination process initiated by the provider or failure to meet/maintain credentialing requirements. ▪ No DHHS approval ▪ No indication process was submitted for review/approval 30 days from date the contract is signed and at the time of change.	MCO response: Initiated. Policies submitted. Pending DHH approval. No corrective action appropriate for deficiency 30 days post contract execution. IPRO response: Determination unchanged. Process and timeliness standard will be reviewed as part of next year's audit.
	The CCN shall develop and implement a provider dispute and appeal process, with DHH's approval, for sanctions, suspensions, and terminations imposed by the CCN against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days	Full	PCCM.D.23 Credentialing Appeal Process shows compliance with standard to develop and implement a provider dispute and appeal process.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	from the date the Contract is signed and at the time of any change.			

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1	**Assurance of Adequate Access and Capacity**			
8.1.1	Access to PCPs	N/A		
8.1.1.1	The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Clinic) or outpatient clinic. The CCN shall agree to provide at least one (1) full-time equivalent (FTE) PCP per twenty-five hundred (2,500) CCN members. The CCN shall ensure each individual PCP shall not exceed a linkage total of 2,500 Medicaid eligibles across all CCN's in which the PCP may be a network provider.	Full	Addressed in PS 08.08.01 Provider Contract and Application.	
8.1.1.2	The CCN may, at its discretion, allow vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by the CCN) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP and become a network provider for the CCN.	Full	Addressed in PS 08.08 Network Development and Management.	
8.1.1.3	The CCN shall provide access to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer]. Network providers must offer office hours at least equal to those offered to the CCN's Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.	Full	Per PS 08.08, providers are encouraged to offer extended office hours through CHS PMPM bonus payment structure. Providers offering extended hours are specified in the Provider Directory.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1.1.4	The CCN shall identify and report to the Enrollment Broker, within seven (7) calendar days, any PCP approved to provide services under the Contract that will not accept new patients or has reached capacity.	Full	Addressed in PS 08.08.	
8.2	**Full-time Definition**			
8.2.0	DHH defines a full time PCP as a provider that provides primary care services for a minimum of twenty (20) hours per week of practice time.	N/A	Definition	
8.3	**PCP/Member Ratio**			
8.3.0	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved in writing by DHH: Physician (Family Practice, General Practice, Internal Medicine Pediatric, OB/GYN) 1: up to 2,500; Nurse Practitioner (not linked to a physician group) 1: up to 1,000; Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.	Substantial	PCP/member ratios are not specifically addressed in the documents provided. IS 08.01 Information Systems New Member Provider Fulfillment includes consideration of providers reaching maximum capacity in assigning members but does not define the acceptable ratios. Non-physician PCPs are not addressed. Capacity Counts Reports also provided that show reporting of PCP/member ratios for individual providers. CHS should develop an overarching policy for network adequacy and capacity or include these requirements in an established policy.	MCO response: Initiated. The Medical Home Enrollment form of our provider subcontract states, in the capacity field, that an MD is allowed a maximum of 2500 linkages and physician extenders (NPs and PAs) are allowed a maximum of 1000 linkages. A policy will be drafted to discuss network adequacy and capacity monitoring by 1/1/14. IPRO response: Determination unchanged. The new policy will be reviewed as part of next year's audit.
8.4	**Travel Time and Distance**			
8.4.0	The CCN shall comply with the following maximum travel time and/or distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps). Requests for exceptions as a result	Full	Addressed in PS 08.08.02 Provider Network Development and Management Plan and geocoding conducted on a quarterly basis. Ad hoc geocoding is conducted when significant changes to the network occur.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of prevailing community standards must be submitted in writing to DHH for approval. The CCN shall ensure that in accordance with usual and customary practices primary care provider services are available on a timely basis.			
8.4.1	Access to Primary Care Providers - travel distance for members living in rural parishes shall not exceed 30 miles; and travel distance for members living in urban parishes shall not exceed 20 miles. Services are considered accessible if they reflect usual practice and travel arrangements in the local area. Exceptions may be approved, by DHH, if the travel distance for medical care exceeds these requirements.	Full	Addressed in PS 08.08.02 Provider Network Development and Management Plan and geocoding conducted on a quarterly basis. Ad hoc geocoding is conducted when significant changes to the network occur. Q4 geocoded map depicting provider locations within 20 and 30 mile radius provided.	
8.5	**Scheduling/Appointment Waiting Times**			
8.5.1	The CCN shall ensure that its network providers have an appointment system for primary care services which is in accordance with prevailing medical community standards as specified below.	N/A	Appointment standards are included in the Provider Handbook and Member Handbook but a process for monitoring provider compliance with these standards is not evident in the documents provided. See below.	
8.5.2	The CCN shall have policies and procedures for these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The CCN shall disseminate these appointment standard policies and procedures to its in-network	Minimal	PS 08.08 states the plan conducts provider surveys of offices to determine compliance with appt. availability, wait time and after-hours coverage. CHS provided PI Early Warning System Performance Measures, SQ 217 dated 7/1-7/31/13. This reports shows the percentage of PCP practices that provide verified 24/7 phone access with ability to speak with PCP practice clinician within 30 minutes of member contact. The minimum performance standard is equal	MCO response: Initiated: PSRs will begin to monitor the appointment availability wait-time and after-hours standards on each quarterly provider visit. Providers are instructed in the Provider Handbook as to appointment standards. CHS conducts surveys of PCP offices to determine compliance with appointment availability, wait time, and after-hours coverage. Results of these surveys will be reported to PRC and QIC for monitoring and development and oversight of corrective action plans

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	providers and to its members. The CCN shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.		to or greater than 95%. The overall plan result was 19.8%. CHS also furnished a Provider Survey performed by Premier Administrative Solutions for First Early Warning Performance Indicator Survey as above. Monthly surveys began in 8/13. CHS plans to have surveyed 100% of PCP practices by end of December 2013. All PCPs to be sampled during after-hours and on weekends; 10% of PCP practices sampled during day. The results reported in the August report show: During business hours – 10% success rate. After-hours – 6% success rate; Weekend – 27% success rate. No practices had any mention of CHS-LA 24 hour nurse line. Neither the SQ217 nor Provider Survey addresses appointment availability. Wait times are also not addressed.	when appointment standards are not met. IPRO response: Determination unchanged. Updated process for monitoring appointment standards will be reviewed as part of next year's audit.
8.6	**Timely Access**			
8.6.1	The CCN shall ensure that medically necessary services are available on a timely basis, as follows: emergent or emergency visits immediately upon presentation at the service delivery site; urgent care within twenty-four (24) hours; non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition; routine, non-urgent, or preventative care visits within six (6) weeks;	Minimal	Addressed in CM 01.42 and Provider Handbook. Documents provided do not address how these requirements are ensured. Neither the SQ217 nor Provider Survey addresses appointment availability. See comments above.	MCO response: Completed. Medically necessary services availability addressed in CM 01.42. Initiated. To address the requirement to ensure compliance with appointment availability, the Provider Handbook will be updated and presented to DHH for approval by 01/01/14. Monitoring Will be implemented with 8.5.2. IPRO response: Determination unchanged. Updated policy and the provider handbook will be reviewed as part of next year's audit.
8.6.2	The CCN shall strive to achieve the	Minimal	Addressed in CM 01.42 and CM 08.03.	MCO response:

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	following timeframes through the development of partnerships/relationships with FFS providers: specialty care consultation within one (1) month of referral or as clinically indicated; lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and		Documents provided do not address how the plan monitors performance against these standards.	Initiated. CHS has the following reports in development that will be available via DDS to ensure that our contracted medical homes can help to monitor compliance: Lab, x-ray and pharmacy activities as well as physician services outside of the medical home. The data for the report is obtained via claims data. Target date for availability of these reports is first quarter 2014. These reports will then be addressed at UMC and QMC to identify network access and utilization opportunities. IPRO response: Determination unchanged. The newly developed reports will be reviewed as part of next year's audit.
8.6.3	Follow-up visits in accordance with ER attending provider discharge instructions.	Minimal	Addressed in CM 01.42. Documents provided do not address how the plan monitors performance against this standard.	MCO response: Initiated. For any member referred to the ER by the Nurse Call line, care management receives a daily report. These members are then followed-up with via telephone. Care management team will incorporate the discharge instructions discussion within this process. Any other member that is currently within the Case Management realm (care management or disease management) similarly receives an outreach call, and the discharge instructions discussion will be addressed. Members utilizing the ER that are not included in Case Management or the Nurse Call group would need to be identified via claims and outreach calls could then be placed to follow up. The ER follow up will be monitored and reported to UMC and incorporated as appropriate within the ER QIP. IPRO response: Determination unchanged. The new process for monitoring performance will be reviewed as part of next year's audit.
8.7	**Maternity Care**			
8.7.1	The CCN shall work with FFS	N/A		

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	provider to try to achieve the following:			
8.7.1.1	An initial appointment for prenatal visits for newly enrolled pregnant women within the following timetables from the postmark date the CCN mails the member's welcome packet: within their first trimester within fourteen (14) days; within the second trimester with seven (7) days; within their third trimester within three (3) days; and high risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;	Minimal	Addressed in CM 01.42 and Provider Handbook. Does not address how these requirements are monitored. No evidence of monitoring to assess compliance provided.	MCO response: Initiated. CHS currently utilizes multiple methods to identify the pregnant member, including Welcome Packet distribution, Member calls, the "834" report, etc. Once identified the member is monitored throughout the pregnancy by the care management team, with outreach calls. Additionally, those members identified with a High Risk pregnancy are assigned to a Nurse Case Manager for follow-up. CHS will incorporate monitoring prenatal visits to the required timetables, including the initial appointment, within these outreach calls. Development of the requisite fields within the software program targeted for completion first quarter 2014. IPRO response: Determination unchanged. The new process for monitoring performance will be reviewed as part of next year's audit.
8.7.2	Initial appointment for CCN members who become pregnant shall be within forty-two (42) days.	Minimal	Addressed in CM 01.42 and Provider Handbook. Does not address how these requirements are monitored. No evidence of monitoring to assess compliance provided.	MCO response: Initiated. CHS currently utilizes multiple methods to identify the pregnant member, including Welcome Packet distribution, Member calls, the "834" report, etc. Once identified the member is monitored throughout the pregnancy by the care management team, with outreach calls. Additionally, those members identified with a High Risk pregnancy are assigned to a Nurse Case Manager for follow-up. CHS will incorporate monitoring prenatal visits to the required timetables, including the initial appointment, within these outreach calls. Development of the requisite fields within the software program targeted for completion first quarter 2014. IPRO response:

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				Determination unchanged. The new process for monitoring performance and the software will be reviewed as part of next year's audit.

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9.4	**Provider Handbooks**			
9.4.1	The CCN shall develop and issue a provider handbook within thirty (30) days of the date the Contract is signed by the CCN. The CCN may choose not to distribute the provider handbook via Surface Mail, provided it submits a written notification to all in network providers that explains how to obtain the provider handbook from the CCN's website. This notification shall also detail how the provider can request a hard copy from the CCN at no charge to the provider. All provider handbooks and bulletins shall be in compliance with state and federal laws. The provider handbook shall serve as a source of information regarding CCN core benefit and services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all CCN requirements are met. At a minimum, the Provider Handbook shall include the following information:	Full	CHS provided Provider Handbook, Version 12, updated 8/13/13.	
9.4.1.1	Description of the CCN;	Full	Addressed in the Provider Handbook.	
9.4.1.2	Description and requirements of NCQA Patient-Centered Medical Home recognition or JACHO Primary Home accreditation;	Full	Addressed in the Provider Handbook.	
9.4.1.3	Core benefits and services the CCN must provide;	Full	Addressed in the Provider Handbook.	
9.4.1.4	Emergency service responsibilities;	Full	Addressed in the Provider Handbook.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9.4.1.5	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;	Substantial	Addressed in the Provider Handbook. Some discrepancies between the Provider Handbook and CHS policy PS 08.04 were noted and are described below under requirement 9.6, Provider Complaint System.	MCO response: Initiated. Provider Handbook is being revised to ensure that the language matches policies and procedures. Target Date to DHH for approval 01/01/14. IPRO response: Determination unchanged. The updated provider handbook will be reviewed as part of next year's audit.
9.4.1.6	Information about the CCN's Grievance System, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;	Substantial	Provider Handbook includes all requirements with the exception of the member's right to request continuation of services while utilizing the grievance system.	MCO response: Initiated. Draft changes have been made to the Provider handbook, to reflect the language used in the member handbook, in order to meet the requirement to address the member's right to request continuation of services while utilizing the grievance system-Target Date to DHH for approval 01/01/14. IPRO response: Determination unchanged. The updated provider handbook will be reviewed as part of next year's audit.
9.4.1.7	Medical necessity definition as defined by DHH;	Full	Addressed in CHS-LA Provider Contract.	
9.4.1.8	Medical necessity review protocols and procedures;	Full	Addressed in the Provider Handbook.	
9.4.1.9	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Full	Addressed in the Provider Handbook. Providers informed that UM criteria and practice guidelines are available upon request.	
9.4.1.10	PCP responsibilities;	Full	Addressed in the Provider Handbook.	
9.4.1.11	Other provider or contract responsibilities;	Full	Addressed in the Provider Handbook.	
9.4.1.12	Prior authorization and referral procedures;	Full	Addressed in the Provider Handbook.	
9.4.1.13	Medical records standards;	Full	Addressed in the Provider Handbook.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9.4.1.14	Claims submission protocols and standards, including instructions and information necessary for a clean and complete claim and samples of clean and complete claims;	Full	Addressed in the Provider Handbook.	
9.4.1.15	CCN prompt pre-processing requirements;	Full	Addressed in the Provider Handbook.	
9.4.1.16	CCN's Chronic Care Management Program;	Full	Addressed in the Provider Handbook.	
9.4.1.17	Quality performance requirements; and	Full	Addressed in the Provider Handbook.	
9.4.1.18	Member rights and responsibilities.	Full	Addressed in the Provider Handbook.	
9.4.2	The CCN shall disseminate bulletins as needed to incorporate any changes to the Provider Handbook.	Full	Samples of provider bulletins were provided.	
9.4.3	Prior to the implementation of the CCN program, the CCN may opt to provide generic provider handbook information. However, the CCN shall make available to network providers a Provider Handbook specific to the CCN Program, no later than thirty (30) days after the date the CCN signs the Contract with DHH.	Full	Provider Handbook is available on the plan's website and a hard copy is available upon request.	
9.4.4	The CCN may opt not to provide a hard copy of the provider handbook to out-of-network providers, however if the CCN does not provide a hard copy the CCN must provide the website address the provider can obtain the CCN's provider handbook and related policies and procedures.	Full	Provider Handbook is available on the plan's website and a hard copy is available upon request.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9.6	**CCN Provider Complaint System**			
9.6.1	The CCN shall establish a Provider Complaint System for in network and out-of-network providers to dispute the CCN's policies, procedures, or any aspect of the CCNs administrative functions. As part of the Provider Complaint system, the CCN shall:	Full	Addressed in PS 08.04, Provider Complaint System.	
9.6.1.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	Full	Staffing: one rep. per DHH region – 9; provider reps conduct quarterly visits and are the provider's initial point of contact.	
9.6.1.2	Identify a staff person specifically designated to receive and process provider complaints;	Full	CHS has a dedicated supervisor and staff.	
9.6.1.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the CCN's written policies and procedures; and	Full	Addressed in PS 08.04.	
9.6.1.4	Ensure that CCN executives with the authority to require corrective action are involved in the provider complaint process as necessary.	Full	Addressed in PS 08.04.	
9.6.2	The CCN shall have and implement written policies and procedures which detail the operation of the Provider Complaint System. The CCN shall submit its Provider Complaint System policies and	Substantial	Addressed in PS 08.04 and the Provider Handbook although discrepancies are noted and are described below. Several avenues for submitting complaints are available, including, but not limited to, provider service representatives, CHS medical directors and the CHS website.	MCO response: Completed. PS 08.04 Provider Complaint System revised to reflect business days rather than calendar days. Due date: 10/25/2013

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	procedures to DHH for review and approval within thirty (30) calendar days of the date the Contract with DHH is signed by the CCN. The policies and procedures shall include, at a minimum:		PS 08.04 states that complaints not resolved at the time of the initial call, require notification of a status report to the provider within 3 business days. When possible the final resolution should occur within 30 business days, and providers notified verbally and in writing. The policy further states that 3 attempts will be made within 30 days to obtain any additional information needed. Also, complaints not resolved within 30 days require communication with the provider within 3 business days to provider advising of the reason for the delay. These 2 latter statements imply 30 calendar days vs. 30 business days. This should be clarified in the policy. Another discrepancy noted: Provider Handbook states that complaints not resolved at the time of the initial call, require a response within one business day to the provider providing a status report. PS 08.04, as noted above, states within 3 business days.	Initiated. Provider Handbook will be revised to align with policy PS 08.04. for response within 3 business days. Target Date to DHH for approval 01/01/14. IPRO response: Determination unchanged. The updated provider handbook and the revised complaint system will be reviewed as part of next year's audit.
9.6.2.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file a complaint with the CCN and the resolution time;	Substantial	Addressed in PS 08.04 and Provider Handbook although time allowed to file a complaint are discrepant. PS 08.04 notes that complaints must be filed within 30 days of the issue or concern. Provider Handbook states that outside of a formal appeal of an adverse determination, no limitation is placed upon the provider of when they may submit a complaint.	MCO response: Initiated. Draft changes have been made to the Provider handbook, to reflect the language used in the member handbook, in order to meet the requirement to address the member's right to request continuation of services while utilizing the grievance system-Target Date to DHH for approval 01/01/14. IPRO response: Determination unchanged. The updated provider handbook will be reviewed as part of next year's audit.
9.6.2.2	A description of how and under what circumstances providers are advised that they may file a complaint with the CCN for issues that are CCN Provider Complaints and under what circumstances a provider may file a complaint	Full	Addressed in the Provider Handbook.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	directly to DHH/MMIS for those decisions that are not a unique function of the CCN.			
9.6.2.3	A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf.	Non-Compliance	Training of provider relations staff is not addressed in documents provided. QIC minutes for 9/20/13 show discussion regarding differentiation between complaints and grievances, and the need for alignment between the Member and Provider Handbooks and the DHH contract.	MCO response: Completed. PS 08.01 revised to include training on the difference between a provider complaint and a grievance/appeal in which a provider is acting on a member's behalf. Member and Provider Handbook aligned with Policy Initiated. Provider relations staff annual compliance training will include definitions and how to differentiate between a provider complaint and a member grievance or appeal in which provider is acting on member's behalf. IPRO response: Determination unchanged. The updated policy and training will be reviewed as part of next year's audit.
9.6.2.4	A process to allow providers to consolidate complaints that involve the same or similar issues, regardless of the number of individual patients or issues included in the bundled complaint;	Full	Addressed in PS 08.04 and Provider Handbook.	
9.6.2.5	A process for thoroughly investigating each complaint using applicable subcontractual provisions, and for collecting pertinent facts from all parties during the investigation.	Full	Addressed in PS 08.04.	
9.6.2.6	A description of the methods used to ensure that CCN executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	Full	Addressed in PS 08.04 and Provider Handbook.	
9.6.2.7	A process for giving providers (or	Full	Addressed in PS 08.04 and Provider Handbook. The	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	their representatives) the opportunity to present their cases in person;		Provider Handbook informs providers that a provider may request to speak directly with the Executive Director or Medical Director.	
9.6.2.8	Identification of specific individuals who have authority to administer the provider complaint process;	Full	Position-specific identification is provided in PS 08.04.	
9.6.2.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	Minimal	CHS maintains a Provider Complaint Log, an example of which is provided in PS 08.04.01. PS 08.02, Provider Services Representatives Responsibilities, instructs reps to address concerns in accordance with PS 08.04 and the PS Provider Complaint System policy and procedure and through use of the Provider Complaint Log. **Provider Complaint File Review** A total of 20 provider complaints were reviewed. The Provider Complaint Log was not provided for each file and when provided, many times was incomplete: did not indicate a date of closure. Files do not consistently follow CHS policy of providing a status report to the provider within 3 business days if the complaint is not resolved at the time of the initial call. Investigation of the complaint is not always evident in the file. **CHS Provider Satisfaction Survey Report** dated 4/30/13 Response rate=11.79% (154/712); 2 mailings were conducted, problems with missing pages was noted in the first mailing. The following results are pertinent to the provider complaint process and the nature of the complaints as they are mostly related to claims issues. 1. Claims 55.84% not know who to contact re: claims pre-processing issues or problems 63.63% satisfied with turnaround time re: claims	MCO response: Completed. Medically necessary services availability addressed in CM 01.42. Initiated. To address the requirement to ensure compliance with appointment availability, the Provider Handbook will be updated and presented to DHH for approval by 01/01/14. Monitoring Will be implemented with 8.5.2. IPRO response: Determination unchanged. The updated provider handbook and policies will be reviewed as part of next year's audit.

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			payments 60.38% satisfied with responsiveness of staff to claim inquiries 61.03% satisfied with completeness and accuracy of feedback to claims inquiries 59.09% satisfied with timeframe re: claims resolution 2. Provider Complaints 29.22% know how to submit a complaint (51.13% excluding non-responders), overall 20-29% satisfaction for questions related to provider complaints	
9.6.2.10	A provision requiring the CCN to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	Full	Addressed in PS 08.04. Reported monthly via the Provider Complaint Summary Report.	
9.6.3	The CCN shall include a description of the Provider Complaint System in the Provider Handbook and include specific instructions regarding how to contact the CCNs Provider Relations staff; and contact information for the person from the CCN who receives and processes provider complaints.	Full	Addressed in the Provider Handbook.	
9.6.4	The CCN shall distribute the CCN's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice of the pre-processed claim. The CCN may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the CCN's website. This summary shall also detail how	Substantial	Addressed in Provider Handbook for in-network providers. Out-of-network providers not addressed, re: distribution of policies/procedures with remittance advice of the pre-processed claim.	MCO response: Initiated. Draft changes have been made to the Provider handbook, to reflect the language used in the member handbook, in order to meet the requirement to address the member's right to request continuation of services while utilizing the grievance system-Target Date to DHH for approval 01/01/14. IPRO response: Determination unchanged. The updated provider handbook will be reviewed as part of next year's audit.

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the in-network provider can request a hard copy from the CCN at no charge to the provider.			
9.6.5	The CCN provider shall file all appeals for the denial, reduction or suspension of medically necessary services through the state fair hearing process.	Full	Addressed in Provider Handbook.	
9.6.5.1	Within fifteen (15) business days of the mailing of the Notice of Adverse Action, the aggrieved provider may request an administrative hearing with the Division of Administrative Law (DAL) by filing a request for administrative hearing with the DAL. After a decision is rendered by the DAL, the aggrieved provider may seek judicial review of the DAL decision within thirty (30) days of the date the final decision is mailed to the parties, pursuant to La. R.S. 49:964. The judicial review petition shall be filed with the 19th Judicial District Court. The District Court's judgment may be appealed, by an aggrieved party, within the appeal time delays set forth in the Louisiana Code of Civil Procedure.	Full	Addressed in PS 08.04.	
9.7	**Materials and Information for Out-of-Network Providers**			
9.7.0	The CCN shall provide the CCN's Grievance System policies and procedures to out-of-network providers upon written or verbal request.	Full	Addressed in PS 08.03, Provider Training.	
9.8	**Reporting Requirements**			
9.8.0	The CCN shall submit to DHH	Full	Provider Complaint Summary Reports were provided	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	monthly Provider Complaint Reports as specified by DHH.		for several months for the period of August 2012 – May 2013. Many reports included the same time frames and/or same reporting periods making it difficult to track the progress from month to month. From the reports provided, the total # of complaints received ranged from a low of 9 (received in August 2012) to a high of 581 (received in March 2013). The number of complaints pending/closed 31-90 days post-file date ranged from 1 (August 2012) to 113 (June 2013). A report for September 2012 showed 0 complaints pending/closed 31-90 days post-file date; however attachment 1 to the report includes 4 cases. Provider Call Center Complaint reports showed complaints received from April 2012-July 2012, with the volume ranging from 8 to 33.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.1	**Enrollment Counseling**			
10.1.10.2	Automatic Assignments by CCN	N/A		
10.1.10.2.1	The CCN is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee: does not make a PCP selection after a voluntary selection of a CCN; or selects a PCP within the CCN that has reached their maximum physician/patient ratio; or selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).	Full	EED.E.1 IS 08.01 Information Systems New Member Provider Fulfillment shows compliance with this standard.	
10.1.10.2.2	Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be autoassigned to a provider who is the assigned PCP for an immediate family member enrolled in the CCN plan. If other immediate family members do not have an assigned PCP, autoassignment shall be made to a provider with whom a family member has a historical provider relationship.	Full	ME.D.4.c MS 08.08.02 Auto Assignment Letters explain to the member the methodology used to select their PCP.	
10.1.10.2.3	If there is no member or immediate family historical usage members shall be autoassigned to a PCP using an algorithm developed by the proposer, based on the age and sex	Full	EED.D.1 IS 08.01 Information Systems New Member Provider fulfillment shows compliance for this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of the member and geographic proximity. The CCN and PCP automatic assignment methodology must be submitted, within thirty (30) days after the Contract is signed by the CCN, for approval by DHH prior to implementation. This methodology must be shared with subcontractors and members prior to enrollment.			
10.1.10.2.4	The CCN shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.	Full	EED.D.1 IS 08.01 Information Systems New Member Provider fulfillment shows compliance for this standard.	
10.1.10.2.5	If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.	Full	EED.D.1 IS 08.01 Information Systems New Member Provider fulfillment shows compliance for this standard.	
10.1.10.2.5.1	Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN.	Full	EED.D.2.a MS 08.33 Primary Care Provider Reassignment shows compliance with this standard.	
10.1.10.2.6	If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must grant the request.	Full	EED.D.2.a MS 08.33 Primary Care Provider Reassignment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.1.10.2.7	The CCN shall have written policies and procedures for allowing members to select a new PCP, including auto-assignment, and provide information on options for selecting a new PCP when it has been determined that a PCP is non-compliant with provider standards (i.e. quality of care) and is terminated from the CCN, or when a PCP change is ordered as part of the resolution to a grievance proceeding. The CCN shall allow members to select another PCP within ten (10) business days of the postmark date of the notice of termination of PCP to members and shall provide information on options for selecting a new PCP.	Full	ME.D.21.d Provider Termination submitted for Eligibility, Enrollment & Disenrollment is P&P regarding reassignment of PCP when a member's PCP is no longer able to treat them.	
10.1.10.2.8	The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11	Disenrollment -Disenrollment is any action taken by DHH or its designee to remove a Medicaid CCN member from the CCN following the receipt and approval of a written request for disenrollment or a determination made by DHH or its designee that the member is no longer eligible for Medicaid or the CCN Program. The CCN shall submit to DHH a quarterly CCN Disenrollment Report which summarizes all disenrollments for its members, in the format specified by DHH. The Enrollment Broker shall be the single point of contact	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to the CCN member for notification of disenrollment.			
10.1.11.1	Member Initiated Request - A member or his/her representative must submit an oral or written request to the Enrollment Broker to disenroll from a CCN. The member may disenroll for the following reasons:	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.1.1	For cause, at any time. The following circumstances are cause for disenrollment: the member moves out of the CCN's designated service area; the CCN does not, because of moral or religious objections, cover the service the member seeks; the member requests to be assigned to the same CCN as family members; the member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the ember to unnecessary risk; if DHH imposes intermediate sanction provisions; the contract between the CCN and DHH is terminated; and other reasons including, but not limited to: poor quality of care; lack of access to CCN core benefits and services covered under the Contract; documented lack of access within the CCN to providers experienced in dealing with the member's healthcare needs; or any	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	other reason deemed to be valid by DHH and/or its agent.			
10.1.11.1.2	Without cause for the following reasons: during the 90 day opt-out period following initial enrollment with the CCN for voluntary members; during the 90 days following the postmark date of the member's notification of enrollment with the CCN; once a year thereafter during the member's annual open enrollment period; upon automatic re-enrollment , if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or if DHH imposes intermediate sanction provisions.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.1.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.1.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.2	CCN Initiated Request	N/A		
10.1.11.2.1	The CCN shall submit requests for involuntary disenrollment of a member that includes, at a minimum, the member's name, ID number, and detailed reasons for requesting the disenrollment utilizing the CCN Request for	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Member Disenrollment to the Enrollment Broker. The CCN shall not request disenrollment for reasons other than those stated in this RFP and the Contract.			
10.1.11.2.2	The following are allowable reasons for which the CCN may request involuntary disenrollment of a member: a member's fraudulent use of the CCN's ID card. (e.g. the member misuses or loans the member's CCN issued ID card to another person to obtain services.) In such cases the CCN shall report the event to the Medicaid Program Integrity Section. The member's behavior is disruptive, unruly, abusive or uncooperative to the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members. The CCN shall take reasonable measures to correct member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.2.3	The CCN shall promptly submit such disenrollment requests to the Enrollment Broker. The CCN 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	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	involuntary disenrollment. The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.			
10.1.11.2.4	All requests will be reviewed on a case-by case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the discussion.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.2.5	DHH approved disenrollment requests shall be assisted and completed by the Enrollment Broker and in a manner so designated by DHH.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.2.6	When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification, or earlier if necessary. Until the enrollee is disenrolled by the Enrollment Broker, the CCN shall be responsible for the provision of services to that member. The Enrollment Broker will provide written notice of disenrollment to the member and request that the member choose a new CCN. The notice shall include a statement that if the member disagrees with the decision to	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	disenroll the member from the CCN, the member has a right to file an appeal directly through the State Fair Hearing process.			
10.1.11.2.7	Until the member is disenrolled by the Enrollment Broker, the CCN shall continue to be responsible for the provision of all core benefits and services to the member.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.2.8	The CCN shall not request disenrollment because of the following: 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 CCN's ability to furnish services to either this particular member or other members; or the member attempts to exercise his/her rights under the CCN's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3	DHH Initiated Disenrollment - DHH will notify the CCN of the member's disenrollment due to the following reasons:	N/A		
10.1.11.3.1	Loss of Medicaid eligibility or loss of CCN enrollment eligibility;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.1.11.3.2	Death of a member;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.3	Member's intentional submission of fraudulent information;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.4	Member is incarcerated;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.5	Member moves out-of-state;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.6	Member becomes Medicare eligible;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.7	Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.8	Member is enrolled in a Medicaid home and community-based services waiver (HDBS);	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.9	Member elects to receive hospice services;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.10	Member requests to be assigned to the same CCN as family members;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.11	The member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.12	The Contract between the CCN and DHH is terminated;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.13	The member loses Medicaid	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	eligibility;		compliance with this standard.	
10.1.11.3.14	The members eligibility changes to an excluded eligibility group;	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	
10.1.11.3.15	To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law.	Full	EED.D.4 INT 08.03 Enrollment and Disenrollment shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.12	**Member Education-Required Materials and Services**			
11.12.0	The CCN shall ensure all materials and services do not discriminate against Medicaid CCN 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 CCN.	Full	ME.D.16.a H-MH1_LA-EN_Member Handbook and ME.D.6 INT 08.02 Member ID Card document complies with this standard.	
11.12.1	New Member Orientation	N/A		
11.12.1.1	The CCN shall have written policies and procedures for the following, but not limited to: orienting new members of its benefits and services; role of the PCP; what to do during the transition period, (e.g. how to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS or CommunityCARE 2.0 to CCN, or from one CCN to another, etc); how to utilize services; what to do in an emergency or urgent medical situation; and how to a file a grievance and appeal.	Full	New Member Orientation P&P, INT 08.06 and Member Bill of Right & Responsibilities indicates compliance with standard.	
11.12.1.2	The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed.	Full	Member's Rights and Responsibilities shows compliance with this standard.	
11.12.1.3	The CCN may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their	N/A		

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	efficacy.			
11.12.1.5	The CCN shall have written policies and procedures for notifying new members within ten (10) business days after receiving notification from the Enrollment Broker of enrollment. This notification must be in writing and include a listing of names, locations, and office telephone numbers that the enrollee may choose as their primary care provider if the file did not contain a PCP selected by the member.	Full	New Member Orientation P&P shows compliance with this standard.	
11.12.1.6	The CCN shall submit a copy of the procedures to be used to contact CCN members for initial member education to DHH for approval within thirty (30) days following the date the Contract is signed by the CCN.	Full	MED.D.1 INT 08.06 New Member Orientation indicates compliance with this standard.	
11.12.1.7	New Medicaid eligibles who have not proactively selected a PCP during the CCN enrollment process or whose choice of PCP is not available will have the opportunity to select a PCP within the CCN that: 1) is a Louisiana Medicaid Program enrolled provider; 2) has entered into a subcontract with the CCN; and 3) is within a reasonable commuting distance from their residence.	Full	ME.D.4.cMS08.08.02 Auto Assignment Letters explain auto assignment and selection of PCP. ME.D.7aCHS LA Provider Directory EXTERNAL (E & S) is sent to members to assist in selecting PCPs.	
11.13	**Communication with New Enrollees**			
11.13.1	Welcome Packets	N/A		

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.13.1.1	The CCN shall send a welcome packet to new members within ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. During the enrollment phase-in implementation (anticipated January 2012 – May 2012) of the CCN program, the CCN may have up to twenty-one (21) days to provide welcome packets.	Full	ME.D.1 INT 08.06 New Member Orientation P&P and ME.D.4a MS 08.08 Welcome Call indicate compliance.	
11.13.1.2	The CCN must mail a welcome packet to the responsible party for each new member. When the family head of household or enrollee name is associated with two (2) or more new members, the CCN is only required to send one welcome packet.	Full	ME.D.4a MS 08.08 Welcome Call and ME.D.4c MS 08.08.02 Auto Assignment Letter indicates compliance with this standard.	
11.13.1.3	All contents of the welcome packet are considered member education materials and, as such, shall be reviewed and approved in writing by DHH prior to distribution according to the provisions in this RFP. Contents of the welcome packets shall include those items specified in the Contract.	Full	ME.D.14.b MKT 08.01 and ME.D.1 INT 08.06 New Member Orientation indicate approval by DHH.	
11.13.1.4	The welcome packet shall include, but is not limited to: a welcome letter highlighting major program features, details that a card specific to the CCN will be sent via mail separately and contact information for the CCN; the CCN Member ID Card (if not mailed under a separate	Full	New Member Orientation, Welcome Call script, and Member ID Card (ME.D.INT 08.02) indicate compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	mailing); a Member Handbook;, and a Provider Directory (also must be available in searchable format on-line).			
11.13.2	Welcome Calls	N/A		
11.13.2.1	The CCN shall make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file from DHH or the Enrollment Broker identifying the new enrollee. During the phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to make welcome calls.	Full	ME.D.4.a MS 08.08 Welcome Call indicates compliance with this standard.	
11.13.2.2	The CCN shall review PCP assignment if automatic assignment is made and assist the member in the process of changing their PCP as needed.	Full	Auto Assignment Letters and Provider Directory indicate compliance with this standard.	
11.13.2.3	The CCN shall develop and submit to DHH for approval a script to be used during the welcome call to discuss the following information with the member: a brief explanation of the program; statement of confidentiality; the availability of oral interpretation and written translation services and how to obtain them free of charge; the concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and	Full	Welcome Call script indicates compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	instructions about changing PCPs; and a discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.			
11.13.2.4	The CCN shall make three (3) attempts to contact the member. If the CCN discovers that the member lost or never received the welcome packet, the CCN shall resend the packet.	Full	ME.D.4.a MS 08.08 Welcome Call shows compliance with standard.	
11.13.2.5	The CCN shall report to DHH on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact.	Substantial	ME.D.4.b MS 08.08.01 Welcome Call Workflow diagram indicates that following three unsuccessful attempts, member record is updated and fed into monthly report of all unsuccessful welcome calls and will be sent to DHH. CHS submitted report SQ097; Initial Member Contact Report for January through June 2013. Report shows Member's last name and Member ID Number only. Does not report member's phone number.	MCO response: Completed. Adequate documentation in place during review. Per DHH direction, Medicaid ID and Last name are provided on the monthly S097 report. Telephone number was removed from the report template on 12/13/2012. No CHS corrective action required. IPRO response: Determination unchanged. The absence of telephone number on the S097 report is noted and will be discussed with the DHH. In the interim, the plan should either add the field to the report or provide the phone number in an accompanying document to be compliant with this standard.
11.14	**CCN Member Handbook**			
11.14.1	The CCN shall develop and maintain a member handbook.	Full	ME.D.16a H-MH1_LA in English, Spanish and Vietnamese submitted and shows compliance for this standard.	
11.14.2	At a minimum, the member	N/A		

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	handbook shall include the following information:			
11.14.2.1	Table of contents;	Full	Member Handbook shows compliance with this standard.	
11.14.2.2	A general description about how CCNs operate, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.3	Member's right to disenroll from CCN;	Full	Member Handbook shows compliance with this standard.	
11.14.2.4	Member's right to change providers within the CCN;	Full	Member Handbook shows compliance with this standard.	
11.14.2.5	Any restrictions on the member's freedom of choice among CCN providers;	Full	Member Handbook shows compliance with this standard.	
11.14.2.6	Member's rights and protections;	Full	Member Handbook shows compliance with this standard.	
11.14.2.7	The amount, duration, and scope of benefits available to the member under the Contract between the CCN and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs, including chronic care management;	Full	Member Handbook shows compliance with this standard.	
11.14.2.8	Procedures for obtaining benefits, including prior authorization requirements;	Full	Member Handbook shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.14.2.9	Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them;	Full	Member Handbook shows compliance with this standard.	
11.14.2.10	The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;	Full	Member Handbook shows compliance with this standard.	
11.14.2.11	The extent to which, and how, after-hours and emergency coverage are provided, including:	Full	Member Handbook shows compliance with this standard.	
11.14.2.11.1	What constitutes an emergency medical condition, emergency services, and post-stabilization services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.11.2	That prior authorization is not required for emergency services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.11.3	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;	Full	Member Handbook shows compliance with this standard.	
11.14.2.11.4	The mechanism, incorporated in the member grievance procedures, by which a member may submit, whether oral or in writing, a service authorization request for the provision of services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.11.5	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by The CCN and	Full	Member Handbook shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.14.2.11.6	That the member has a right to use any hospital or other setting for emergency care;	Full	Member Handbook shows compliance with this standard.	
11.14.2.12	The post-stabilization care services rules;	Full	Member Handbook shows compliance with this standard.	
11.14.2.13	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Full	Member Handbook shows compliance with this standard.	
11.14.2.14	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the CCN's Contract with DHH, including pharmacy cost sharing for certain adults;	Full	New Member Orientation P&P shows compliance with this standard.	
11.14.2.15	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 CCN if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Full	Member Handbook shows compliance with this standard.	
11.14.2.16	For counseling or referral services that the CCN does not cover because of moral or objections, the CCN should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Full	New Member Orientation P&P shows compliance with this standard.	
11.14.2.17	Member grievance, appeal and state fair hearing procedures and time frames;	Full	Member Handbook shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.14.2.18	Grievance, appeal and fair hearing procedures that include the following:	N/A		
11.14.2.18.1	For State fair hearing:	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.1.1	The right to a hearing;	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.1.2	The method for obtaining a hearing; and	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.1.3	The rules that govern representation at the hearing.	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.2	The right to file grievances and appeals;	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.3	The requirements and timeframes for filing a grievance or appeal;	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.4	The availability of assistance in the filing process;	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.5	The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.6	The fact that, when requested by the member:	N/A		
11.14.2.18.6.1	Benefits will continue if the member files an appeal or a request for state fair hearing within the timeframes specified for filing; and	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.6.2	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.	Full	Member Handbook shows compliance with this standard.	
11.14.2.18.7	In a State Fair Hearing the Division	Full	Member Handbook shows compliance with this	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether services must be provided.		standard.	
11.14.2.19	Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Full	Member Handbook shows compliance with this standard.	
11.14.2.20	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Full	Member Handbook shows compliance with this standard.	
11.14.2.21	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.22	How to obtain emergency and non-emergency medical transportation;	Full	Member Handbook shows compliance with this standard.	
11.14.2.23	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Full	Member Handbook shows compliance with this standard.	
11.14.2.24	Information about the requirement that a member shall notify the CCN immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	Full	Member Handbook shows compliance with this standard.	
11.14.2.25	Reporting requirements for the	Full	Member Handbook shows compliance with this	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the CCN;		standard.	
11.14.2.26	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the CCN or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Full	Member Handbook shows compliance with this standard.	
11.14.2.27	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, Spanish and Vietnamese;	Full	Member Handbook shows compliance with this standard.	
11.14.2.28	Information on the member's right to a second opinion at no cost and how to obtain it;	Full	Member Handbook shows compliance with this standard.	
11.14.2.29	Any additional text provided to the CCN by DHH or deemed essential by the CCN;	N/A		
11.14.2.30	The date of the last revision;	Full	Member Handbook shows compliance with this standard.	
11.14.2.31	Additional information that is available upon request, including the following: information on the structure and operation of the CCN;	Full	Member Handbook shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	physician incentive plans; service utilization policies; and how to report alleged marketing violations to DHH utilizing the Marketing Complaint Form.			
11.15	**Member Identification (ID) Cards**			
11.15.1	CCN members will receive two (2) member identification cards.	Full	ME.D.6 INT 08.02 and Member Handbook show compliance with this standard.	
11.15.1.1	A DHH issued ID card to all Medicaid eligibles, including CCN members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by CCN providers. These systems will contain the most current information available to DHH, including specific information regarding CCN enrollment. There will be no CCN specific information printed on the card. The CCN member will need to show this card to access Medicaid services not included in the CCN core benefits and services. A CCN issued member ID card that contains information specific to the CCN.	Full	Member Handbook shows compliance with this standard.	
11.15.1.1.1	The members ID card shall at a minimum include, but not be limited to the following: the member's name and date of birth; the CCN's name and address; instructions for emergencies; the PCP's name and telephone numbers (including after-hours number, if different from business hours	Full	Member Handbook shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	number);and the toll-free number(s) for: 24-hour Member Services and Filing Grievances -- Provider Services and Prior Authorization and Reporting Medicaid Fraud (1-800-488-2917).			
11.15.2	The CCN may issue provide the CCN member ID card in a separate mailing from the welcome packet, however the card must be sent no later than ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. As part of the welcome packet information, the CCN must explain the purpose of the card, how to use the card, and how to use it in tandem with the DHH-issued card.	Full	Member Handbook and Member ID Card Policy show compliance with this standard.	
11.15.3	The card may be issued without the PCP information if no PCP selection has been made on the date of the mailing.	Full	Member ID Card Policy shows compliance with this standard.	
11.15.4	Once PCP selection has been made by the member or through auto assignment, the CCN will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the CCN must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous car.	Full	Member ID Card Policy ME.D.6 INT 08.02 shows compliance with this standard.	
11.15.5	The CCN shall reissue the CCN ID card within ten (10) calendar days	Full	Member ID Card Policy ME.D.6 INT 08.02 shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of notice that a member reports a lost card, there is a member name change or the PCP changes, or for any other reason that results in a change to the information on the member ID card.			
11.15.6	The holder of the member identification card issued by the CCN shall be a CCN member or guardian of a member. If the CCN has knowledge of any CCN member permitting the use of this identification card by any other person, the CCN shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-2917.	Full	Member ID Card Policy ME.D.6 INT 08.02 shows compliance with this standard.	
11.15.7	The CCN shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all core benefits and services and/or expanded services and out of network services.	Full	Member ID Card Policy ME.D.6 INT 08.02 shows compliance with this standard.	
11.16	**Provider Directory for Members**			
11.16.1	The CCN shall develop and maintain a Provider Directory in four (4) formats:	N/A		
11.16.1.1	A hard copy directory for members and upon request, potential members;	Full	Member Handbook informs members they may request a hard copy directory by calling CHS-LAQ.	
11.16.1.2	Web-based, searchable, online directory for members and the	Full	Member Handbook and Provider Directory informs members they may access the provider directory via	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	public;		the website at Louisiana.chsamerica.com.	
11.16.1.3	Hard copy, abbreviated version for the Enrollment Broker; and	Minimal	The plan provided an Internal and External Provider Directory for review. It is not explicitly documented that these directories are shared with the enrollment broker. Post onsite the plan forwarded P/P IS 08.01. New Member/Provider/Fulfillment; this document references electronic file directory only. Recommendation The plan should identify in policy/procedure how hard copy provider directories are shared with the enrollment broker.	MCO response: Completed. Documentation is in place confirming the submission of the Provider Registry and Provider Registry Site files by Molina. Policy updated to specify how hard-copies of provider directories are shared with the enrollment broker. IPRO response: Determination is unchanged. Updated policy will be reviewed as part of next year's audit.
11.16.1.4	Electronic file of the directory for the Enrollment Broker.	Full	The CCN capacity for electronic file transfer of medical home assignments is referenced and described in P/P IS 08.01. New Member/Provider/Fulfillment.	
11.16.2	DHH or its designee shall provide the file layout for the electronic directory to the CCN after approval of the Contract. The CCN shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed by the CCN.	Full	The plan submitted templates of its provider directory to DHH for readiness review.	
11.16.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill requests by potential members. The web-based online version shall be updated in real time, however no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to the new Medicaid enrollees. Format for this	Full	Provider Directory External English shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	version will be in the format specified by DHH. The electronic version shall be updated prior to each submission to DHH's Fiscal intermediary and the Enrollment Broker. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly.			
11.16.4	The Provider Directory shall include, but not be limited to: names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, specialists, and hospitals at a minimum, that are not accepting new patients; identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area; identification of any restrictions on the enrollee's freedom of choice among network providers; and 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).	Full	Provider Directory EXTERNAL shows compliance with this standard.	
11.16.5	To assist Medicaid potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make	N/A	Enrollment Broker responsibility	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	available, (by mail) paper provider directories which comply with the member education material requirements of this RFP.			
11.17	**Member Call Center**			
11.17.1	The CCN shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as: explanation of CCN policies and procedures; prior authorizations; access information; information on PCPs or specialists; referrals to participating specialists; resolution of service and/or medical delivery problems; and member grievances.	Full	Member Handbook indicates compliance with this standard. PAS Contract and PAS website verifies that the member service call center is located in St. Petersburg, FL.	
11.17.2	The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding State declared holidays. The toll-free line shall have an automated system available 24-hour a day, seven days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency, and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The CCN must ensure that the voice mailbox	Full	ME.D.11a MS 08.01 Call Center Performance Standards complies with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.			
11.17.3	The CCN shall have sufficient telephone lines to answer incoming calls. The CCN shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not meet or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.	Full	ME.D.9.b MS 08.14.01 Overflow of Calls and ME.D.9.a MS 08.14 Member Services Staffing show compliance with this standard.	
11.17.4	The CCN must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for CCN performance. The CCN must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.	Full	ME.D.11.a Call Center Performance Standards and MS 08.01 Member Services Staffing show compliance with this standard.	
11.17.5	The CCN must develop telephone help line policies and procedures that address staffing, personnel,	Full	ME.D.11.a MS 08.01 Call Center Performance Standards show compliance and address staffing, personnel, hours of operation, access and response standards,	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The CCN shall submit these telephone help line policies and procedures, including performance standards, to DHH for written approval prior to implementation of any policies. This must include a capability to track and report information on each call. The CCN call center must have the capability to produce an electronic record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.		monitoring of calls. Call Center has capability to produce electronic records and track information regarding reporting requirements.	
11.17.6	The CCN shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The CCN shall submit call center quality criteria and protocols to DHH for review and approval annually.	Full	ME.D.11a MS 08.01 Call Center Performance Standards shows compliance with this standard.	
11.17.7	Automatic Call Distribution - The CCN shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:	Full	Call Center Performance Standards shows compliance with this standard.	
11.17.7.1	Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	Full	Call Center Performance Standards shows compliance with this standard.	
11.17.7.2	Transfer calls to other telephone	Full	ME.D.9.b MS 08.14.01 Overflow of Calls shows	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	Contract Requirement Language	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	MCO Response and Plan of Action
	lines;		compliance with this standard.	
11.17.7.3	Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;	Full	ME.D.10.s MS 08.04 Member Services Quality Monitoring shows compliance with this standard.	
11.17.7.4	Provide a message that notifies callers that the call may be monitored for quality control purposes;	Full	Call Center Performance Standards indicate compliance with this standard.	
11.17.7.5	Measure the number of calls in the queue at peak times;	Full	Call Center Performance Standards indicate compliance with this standard.	
11.17.7.6	Measure the length of time callers are on hold;	Full	Call Center Performance Standards I and Real Time Statistical monitoring indicate compliance with this standard.	
11.17.7.7	Measure the total number of calls and average calls handled per day/week/month;	Full	ME.D.12.a MS 08.02 Call Center Reporting shows compliance with this standard.	
11.17.7.8	Measure the average hours of use per day;	Full	ME.D.12.a MS 08.02 Call Center Reporting shows compliance with this standard.	
11.17.7.9	Assess the busiest times and days by number of calls;	Full	ME.D.12.a MS 08.02 Call Center Reporting shows compliance with this standard.	
11.17.7.10	Record calls to assess whether answered accurately;	Full	ME.D.12.a MS 08.02 Call Center Reporting shows compliance with this standard.	
11.17.7.11	Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the	Full	CHS submitted documentation that they have two connections for network connectivity; Century Link and TW Telecom. In the event that one network connection was to become unavailable the office will still be able to connect via the second network connection and	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	telephone lines are not disrupted;		provides cell phones to employees as needed. InContact provides disaster recovery services and is able to route calls to other locations.	
11.17.7.12	Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and	Full	Verified via accessing the Member Services phone number.	
11.17.7.13	Inform the member to dial 911 if there is an emergency.	Full	Verified via accessing the Member Services phone number.	
11.17.7.14	Performance Standards - Answer ninety-five (95) percent of calls within thirty (30) seconds or an automatic call pickup system; - No more than one percent (1%) of incoming calls receive a busy signal; Maintain an average hold time of three (3) minutes or less; Maintain abandoned rate of calls of not more than five (5) percent. The CCN must conduct ongoing quality assurance to ensure these standards are met. If DHH determines that it is necessary to conduct onsite monitoring of the CCN's member call center functions, the CCN is responsible for all reasonable costs incurred by DHH or its authorized Agent(s) relating to such monitoring.	Substantial	ME.D.11.a MS 08.0 Call Center Performance Standards note the following standards: 90% of calls answered within 30 seconds or less. Standard should be 95%.	MCO response: Completed. MS 08.0 Call Center Performance Standards policy updated to comply with Amendment 2 of the contract, which identifies Standard to be 95% of calls answered within 30 seconds or less. Review of reports to date indicates compliance with the 95% requirement. DHH report template continues to indicate 90% standard. IPRO response: Determination is unchanged. Performance will be assessed as part of next year's audit. The discrepancy between the DHH template and the standard is noted and will be brought to the attention of the state.
11.18	**Member's Rights and Responsibilities**			
11.18.0	The CCN shall have written policies regarding member rights and responsibilities. The CCN shall comply with all applicable state and federal laws pertaining to member	Full	ME.D.15.a MS 08.05 Member's Rights and Responsibilities shows compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	rights and privacy. The CCN shall further ensure that the CCN's employees, contractors and CCN providers consider and respect those rights when providing services to members.			
11.18.1	Members Rights - The rights afforded to current members are detailed in Appendix S, Members' Bill of Rights.	Full	ME.D.15.b MS 08.05.01 Member Bill of Right & Responsibilities complies with this standard.	
11.18.2	Member Responsibilities	N/A		
11.18.2.1	The CCN 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.	Full	ME.D.15.b MS 08.05.01 Member Bill of Right & Responsibilities complies with this standard.	
11.18.2.2	The CCN members' responsibilities shall include but are not limited to: informing the CCN of the loss or theft of their ID card; presenting their CCN ID card when using health care services; being familiar with the CCN procedures to the best of the member's abilities; calling or contacting the CCN to obtain	Full	ME.D.15.b MS 08.05.01 Member Bill of Right & Responsibilities complies with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	information and have questions answered; providing participating network providers with accurate and complete medical information; asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; living healthy lifestyles and avoiding behaviors known to be detrimental to their health; following the grievance process established by the CCN 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.			
11.19	**Notice to Members of Provider Termination**			
11.19.1	The CCN shall make a good faith effort to give advance 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	Full	ME.D.21a and ME.D.21d Provider Termination PCP were submitted and reviewed. Letters are sent to members as notification that their PCP can no longer provide services to members and advises member of importance of selecting a new PCP. INT 08.07 Provider Termination Notification and INT 08.07.01 Provider Termination Notification letter were submitted showing compliance with the standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	notice from the provider.			
11.19.2	The CCN shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.	Non-Compliance	No evidence was found that a written notice will be provided within 10 days if member has been receiving a prior authorized treatment. Revision to UM 08.04 Service Authorizations, Determinations and Notifications was not active during the period for this review. Post on-site, CHS submitted UM 08.04 Service Authorizations, Determinations and Notifications. This Policy shows a revision date of 9/23/13 and added text on page 5: If a treating provider becomes unavailable for a prior authorized service or course of treatment, written notice to the member shall be provided within 10 calendar days from the date that CHS –LA becomes aware of such, if it is prior to the change occurring.	MCO response: Completed. Letter approved by DHH on 11/6/2013 to begin use on 11/7/2013, for written notice to member receiving a prior authorized course of treatment when the treating provider becomes unavailable. Documentation that letter is sent within the 10 calendar days from the date upon which the CCN becomes aware will be maintained in the Member's record. IPRO response: Determination is unchanged. Letter and documentation will be reviewed as part of next year's audit.
11.19.3	The requirement to provide notice prior to the dates of termination, shall be waived when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the GSA service area and fails to notify the CCN, or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately (same day) upon the CCN becoming aware of the circumstances.	Full	INT 08.07 Provider Termination Notification submitted that shows compliance with this standard.	
11.20	**Additional Member Educational Materials and Programs**			
11.20.0	The CCN shall prepare and distribute educational materials, including, but not limited to, the following:	N/A		
11.20.1	Bulletins or newsletters distributed	Non-	CHS does not have Member Bulletins and Newsletter to	MCO response:

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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;	Compliance	meet this standard. CHS stated it does not have Member Bulletins or Newsletters at this time, but are planning to develop for distribution to members.	Completed. A section has been added to the CHS-LA website that identifies Educational classes available. Fall Newsletter Mailed out on 10/9/13. Initiated. Winter Newsletter targeted mail date NLT 12/22/13. IPRO response: Determination is unchanged. Website and newsletter will be reviewed as part of next year's audit.
11.20.2	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Full	ME.D.20.a Baby Steps Calendar, Educational Flyer book/cover letter show compliance with this standard.	
11.20.3	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Full	Educational books specific to Asthma, Sickle Cell, Diabetes, Hypertension, COPD, CAD, CHF show compliance with the standard.	
11.20.4	Materials focused on health promotion programs available to the members;	Full	Member Handbook shows compliance with this standard.	
11.20.5	Communications detailing how members can take personal responsibility for their health and self management;	Full	Member Handbook and Health Risk Assessment mailing shows compliance with this standard.	
11.20.6	Materials that promote the availability of health education classes for members;	Non-Compliance	Documents provided do not address educational materials that promote the availability of health education classes for members.	MCO response: Completed. A section has been added to the CHS-LA website that identifies Educational classes available. Fall Newsletter

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			CHS stated it does not have Member Bulletins or Newsletters at this time but the plan is planning to develop for distribution to members to inform them of the availability of health education classes.	Mailed out on 10/9/13. Initiated. Winter Newsletter targeted mail date NLT 12/22/13. IPRO response: Determination is unchanged. Website and newsletter will be reviewed as part of next year's audit.
11.20.7	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Full	Educational books specific to Asthma, Sickle Cell, Diabetes, Hypertension, COPD, CAD, CHF show compliance with the standard.	
11.20.8	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Full	Educational books specific to Asthma, Sickle Cell, Diabetes, Hypertension, COPD, CAD, CHF show compliance with the standard.	
11.20.9	Notification to its members of their right to request and obtain the welcome packet at least once a year;	Non-Compliance	INT 08.06 New Member Orientation revised was not active during the period of this review. INT 08.06 New Member Orientation was submitted for review prior to the on-site and did not state that a member could request a Welcome Packet at least one time per year. Post on-site, CHS submitted INT 08.06 New Member Orientation revised 09/18/2013 with the added statement: the member has the right to request a Welcome Packet at least once a year.	MCO response: Completed. Post on-site, CHS submitted INT 08.06 New Member Orientation revised 09/18/2013 with the added statement: the member has the right to request a Welcome Packet at least once a year. IPRO response: Determination is unchanged. Policy will be reviewed as part of next year's audit.
11.20.10	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	Non-Compliance	INT 08.08 Member Notification of DHH Changes was not active during the period of this review. Post on-site, CHS submitted new policy INT 08.08 Member Notification of DHH Changes with an effective date of 9/20/2013. This P&P states CHS will notify member of any changes that DHH defines as significant at least thirty (30) calendar days before the intended effective date.	MCO response: Completed. Post on-site, CHS submitted INT 08.06 New Member Orientation revised 09/18/2013 with the added statement: the member has the right to request a Welcome Packet at least once a year. IPRO response: Determination is unchanged. Policy will be reviewed as

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				part of next year's audit.
11.20.11	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	Full	MKT 08.01 Written Materials Guidelines for Marketing shows compliance with this standard.	
11.21	**Oral and Material Interpretation Services**			
11.21.1	The CCN 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 and Vietnamese). The enrollee is not to be charged for interpretation services. The CCN must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.	Full	ME.D.14.a MS 08.20 Translator Services and Member Bill of Right & Responsibilities show compliance with this standard.	
11.21.2	The CCN shall ensure that where at least five percent (5%) or more of the resident population of a parish and/or service area is non-English speaking and speaks a specific foreign language, that materials are made available, at no charge, in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately.	Full	ME.D.14.b MKT 08.01 Written Materials Guidelines and RFP (section 11/10/6) language indicates compliance with this standard.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.22	**Marketing, Reporting, and Monitoring**			
11.22.1	Reporting to DHH	N/A		
11.22.1.1	The CCN must provide a monthly report in a format prescribed by DHH to demonstrate the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.	Substantial	Reports submitted indicate compliance with Marketing and Member Education plan requirements: SM109 Marketing Activities Report 2012 09 (2) SM109 Marketing Activities Report 2012 09 (3) SM109 Marketing Activities Report 2012 09 SM109 Marketing and Member Education Events 2013 02 SM109 Marketing and Member Education Materials Distributed 2012 10 (1) SM109 Marketing and Member Education Materials Distributed 2012 10 (2) SM109 Marketing and Member Education Materials Distributed 2012 10 (3) Reports note due date as the 15th of the month following end of reporting period vs. contract requirement of the 10th day of the following month.	MCO response: Completed. Report revised to include correct due date rather than the 15th of the following month. IPRO response: Determination is unchanged. Corrected report will be reviewed as part of next year's audit.
11.22.1.2	A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year.	Substantial	SM109Monthly Marketing Report 2012 08 SM109Monthly Marketing Report 2012 11 SM109Monthly Marketing Report 2013 01 Monthly Marketing Reports submitted. A Marketing Activities Annual Review 2012 was submitted but did not include a summary report of all marketing and member education efforts submitted to DHH within 30 days of the end of the calendar year.	MCO response: Completed. A Marketing Activities Annual Review 2012 was submitted but did not include a summary report of all marketing and member education efforts submitted to DHH within 30 days of the end of the calendar year. A Summary report has been added to list of reports due to DHH and ownership assigned. IPRO response: Determination is unchanged. Summary report will be reviewed as part of next year's audit.

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.0	**Member Grievances and Appeals**			
12.0.1	The CCN shall have a grievance system in place that includes a grievance process and access to a state fair hearing. The system shall comply with the requirements set forth in all federal and state laws and regulations. The CCN shall have written policies and procedures describing the grievance system. The CCN shall provide the policies and procedures to the Department for approval within thirty (30) days after the Contract is signed by the CCN and prior to implementation of any proposed revisions.	Substantial	Addressed in INT 01.18, Complaint/Grievance Process. File review revealed that a statement regarding the member's right to a State Fair Hearing is not included in denials related to a lack of information.	MCO response: Completed. As noted during on site visit, the Member Handbook (p. 11): "if a member does not agree with an 'action', such as a reduction, limit or denial of service(s) your doctor prescribed for you, you may ask for an appeal through a State Fair Hearing." Additionally, as of 10/23/13, the language regarding the request for an appeal through State Fair Hearing has been added to the Lack of Information Notification letter to the member. IPRO response: Determination is unchanged. File review will be conducted as part of next year's audit, which will include a review of the Lack of Information Notification letter.
12.0.2	The CCN shall have a staff member designated as the grievance system coordinator and any additional staff necessary to comply with the requirements of this section, including those related to timeliness.	Full	Addressed in 01.18, Complaint/Grievance Process. Any staff member can receive a complaint. QM is responsible for addressing complaints.	
12.0.3	The CCN shall dispose of the grievance and notify the member in writing of the resolution in a timely manner that is appropriate for the complexity of the grievance and the member's health condition. Most grievances should be resolved within ten (10) business days of	Full	01.18, Complaint/Grievance Process, describes the process, from receipt to resolution, including timeliness standards.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	receipt or sooner. All grievances shall be resolved within the time frames specified below. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances in accordance with all applicable state and federal laws. All appeals received by the CCN must be logged and directly forwarded to the State Fair Hearing process.			
12.1	**Definitions**			
12.1.1	Action - A termination, suspension, or reduction (which includes denial of a service based on Federal Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services.	Full	Addressed in 01.18 Complaint/Grievance Process.	
12.1.2	Appeal - A request for review of an action.	Full	Addressed in 01.18 Complaint/Grievance Process.	
12.1.3	Grievance - An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes CCN	Full	Addressed in 01.18 Complaint/Grievance Process.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	level grievances and access to State Fair Hearing.			
12.2	**General Requirements**			
12.2.1	Grievance System - The CCN must have a system in place for members that include a grievance process, and access to the State Fair Hearing system.	Full	Policy 01.18 Complaint/Grievance Process, describes the step by step process in which grievances are handled.	
12.2.2	Filing Requirements	N/A		
12.2.2.1	Authority to File	N/A		
12.2.2.1.1	A member or representative of their choice may file a grievance and may request a State Fair Hearing in response to an action	Full	Member or representative can file a grievance as per 01.18 Complaint/Grievance Process.	
12.2.2.1.2	A network provider may file a grievance or request a State Fair Hearing on behalf of a member in response to an action.	Full	A provider may file on behalf of a member as per 01.18 Complaint/Grievance Process.	
12.2.2.1.3	The CCN shall assure that no punitive action is taken against a provider who files a grievance on behalf of a member or supports a member's grievance.	Full	Addressed in 08.02 State Fair Hearing Policy.	
12.2.2.2	Timing - The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action to request a State Fair Hearing. Within the timeframe the member, or a representative or provider acting on their behalf, may request a State Fair Hearing.	Full	Members are allowed 30 days as per member Handbook.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.2.2.3	Procedures	N/A		
12.2.2.3.1	The member may file a grievance either orally or in writing with the CCN.	Full	Defined in 01.18 Complaint/Grievance Process	
12.2.2.3.2	The member, or a representative or provider acting on behalf of the member, may file for a State Fair hearing with the designated state entity either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed State Fair Hearing request.	Full	Included in Non-Certification Determination QM 01.18 and State Fair Hearing Policy QM 08.02.	
12.3	**Notice of Grievance and State Fair Hearing Procedures**			
12.3.1	The CCN shall ensure that all CCN members are informed of State Fair Hearing process and of the CCN's grievance procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance procedures. Forms on which members may file grievances, concerns or recommendations to the CCN shall be available through the CCN, and must be provided upon request of the member. The CCN shall make all forms easily available on the CCN‘s website.	Full	Included in Non-Certification Determination QM 01.18, and QM 08.02 State Fair Hearing Policy.	
12.4	**Grievance Records and Reports**			
12.4.1	The CCN shall maintain a log of all grievances and requests for fair	Full	Evidenced by the State Hearing Summary Report and QIC 092013 Minutes.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	hearings that shall be available to the Department in electronic format upon request.			
12.4.2	The CCN log shall be specific to the members covered by this RFP; entries in the log shall not be intermingled with entries about members from the CCN's other lines of business.	Full	Member IDs is a required element in the State Hearing Summary Report.	
12.4.3	At a minimum, the log shall contain: the member's name and member ID number; the date of filing; a description of the issue; the date of resolution; a description of the resolution; whether the grievance was determined valid; and the date of member notification.	Full	Evidenced by the State Hearing Summary Report.	
12.4.4	A copy of the grievances log shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	Full	Six year retention period is included in the State Fair hearing Policy 08.02.	
12.4.5	The CCN shall provide quarterly reports in electronic format to DHH by the fifth (5th) calendar day of the following end of the quarter, that include all grievances and, if	Full	Quarterly Grievance and State Hearing Reports are prepared and were submitted for review.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	reached, their resolutions. The reports covering the previous quarter (January-March, April-June, July-September and October-December), shall include information about any trends that have been identified and interventions that may have been implemented.			
12.4.6	These reports with PHI redacted will be made publicly available for inspection.	Full	Notation that PHI is redacted is made on the Grievance Summary reports.	
12.5	**Handling of Grievances**			
12.5.0	The grievance procedures shall be governed by the following requirements:	N/A		
12.5.1	General Requirements - In handling grievances, the CCN must meet the following requirements:	N/A		
12.5.1.1	The CCN shall give members reasonable assistance in completing grievance and other procedural steps, including, but not limited to, providing a toll-free telephone number, translation services, and a toll-free number with Telephone Typewriter (TTY)/Telecommunication Device for the Deaf (TDD) and interpreter capability.	Substantial	Members are given a toll-free number to call: 855-chs-la4u. There is a policy regarding availability of translation and TTY services but this opportunity doesn't appear to be included in communication to members filing grievances.	MCO response: Initiated. Draft changes made to the provider handbook-Target Date 01/01/14. IPRO response: Determination is unchanged. Updated member handbook will be reviewed as part of next year's audit.
12.5.1.2	Acknowledge receipt of each grievance.	Full	Addressed in INT 01.18 Complaint/Grievance Process.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.5.2	Resolution and Notification - Basic Rule: The CCN must dispose of a grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in 12.5.2.1 below.	Full	Addressed in INT 01.18 Complaint/Grievance Process.	
12.5.2.1	Specific Timeframes	N/A		
12.5.2.1.1	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 CCN receives the grievance. Extension of Timeframes. The CCN may extend the timeframes of this section by up to fourteen (14) calendar days if: the member requests the extension; or the CCN 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. Requirements Following Extension - If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	Full	Addressed in INT 01.18 Complaint/Grievance Process.	
12.5.3	Requirements for State Fair Hearings	N/A		
12.5.3.1	Availability - The member may request a State Fair Hearing within thirty (30) days from the date of the	Full	Addressed in INT 01.18.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	notice of action following the resolution of the grievance.			
12.5.3.2	Parties - The parties to the State Fair Hearing include the CCN as well as the member and his or her representative or the representative of a deceased member's estate.	Full	Addressed in 08.02.	
12.5.3.3	Concurrent Appeal Review - The CCN shall conduct an internal concurrent review for each appeal for which a State Fair Hearing is requested. The purpose of the Concurrent Appeal Review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the State Fair Hearing. The CCN shall notify the State Fair Hearing designated entity of Concurrent Appeal reviews resulting in a resolution in favor of the member. The Concurrent Appeal Review shall not delay the CCN's submission of an appeal to the State Fair Hearing process and shall not delay the review of the appeal in the State Fair Hearing.	Substantial	Policy 08.08 discusses the State Fair Hearing Process and the concurrent plan appeal process. There was one case made available for file review where the notification to the member should have included a statement that services will continue pending resolution and that the member retains the right to benefits during the process. Also, if the appeal is not upheld, the member may be liable for the cost of the service. Though it did not appear in this one case reviewed onsite, such language is included in the plan's policy.	MCO response: Completed. Although requirement is addressed in policy, documentation to member omitted the requisite language. Template has been revised and required language included. IPRO response: Determination is unchanged. Updated template will be reviewed as part of next year's audit.
12.5.4	Special Requirements for State Fair Hearing - All State Fair Hearing by members or on their behalf shall be filed with the state designated entity; however, if the CCN receives a State Fair Hearing request, the request shall be forwarded directly	Full	Addressed in 08.02 State Fair Hearing Policy.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to the designated entity that will conduct the State Fair Hearing.			
12.5.4.1	The CCN's staff shall be educated concerning the importance of the State Fair Hearing procedures and the rights of the member and providers.	Full	Addressed in 08.02 State Fair Hearing Policy.	
12.5.4.2	The appropriate individual or body within the CCN that made the decision that is being brought to the State Fair Hearing shall be identified. This individual shall prepare the Summary of Evidence and be available for the State Fair Hearing either in person or by telephone.	Full	Addressed in 08.02 State Fair Hearing Policy.	
12.6	**Notice of Action**			
12.6.0	Notice of Action will only be sent by the CCN in certain circumstances as specified in this RFP.	Full	Addressed in 08.02 State Fair Hearing Policy.	
12.6.1	Language and Format Requirements - The notice must be in writing and must meet the language and format requirements of to ensure ease of understanding.	Full	Policy 08.02 State Fair Hearing Policy states that the notice must be in writing.	
12.6.2	Content of Notice - The notice must explain the following:	N/A		
12.6.2.1	The action the CCN or its contractor has taken or intends to take;	Full	Addressed in Policy 08.02.	
12.6.2.2	The reasons for the action;	Full	Addressed in Policy 08.02.	
12.6.2.3	The member's right to request a	Full	Addressed in Policy 08.02.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	State Fair Hearing and a number to call for free Legal Advice;			
12.6.2.4	The procedures for exercising the rights specified in this section;	Full	Addressed in Policy 08.02.	
12.6.2.5	The circumstances under which expedited resolution is available and how to request it; and	Full	Addressed in Policy 08.01 Complaint/Grievance process.	
12.6.2.6	The member's right to have benefits continues 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.	Non-Compliance (determination changed to Substantial)	The member's right to have benefits continue pending resolution doesn't appear to be addressed in a policy statement nor does it seem to be present in member communications.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal process. IPRO response: Based on a re-review of the member handbook, determination changed to "Substantial."
12.6.2.7	A statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free number to call to receive translation of the notice.	Substantial	Member handbooks are available in Spanish and Vietnamese, but it's not clear how members are notified regarding the availability of these handbooks.	MCO response: Initiated. DHH provides notification upon enrollment application submission, indicating to CHS the primary-alternative language of the Applicant/Member. CHS provides member handbooks in the alternative language according to the application notice. Member handbook updated to highlight the statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free number to call to receive

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				translation of the notice- Target Date 01/01/14 IPRO response: Determination is unchanged. Updated handbook will be reviewed as part of next year's audit.
12.6.3.8	Timing of Notice - The CCN must mail the notice within the following timeframes:	N/A		
12.6.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action.	Full	Addressed in 08.04 Service Authorizations Determinations and Notifications.	
12.6.3.2	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, requests extension; or the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	Addressed in 08.04.	
12.6.3.3	If the CCN extends the timeframe it must: give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as	Full	Addressed in 08.04.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	expeditiously as the member's health condition requires and no later than the date the extension expires.			
12.6.3.4	On the date the timeframe for service authorization expires.	Full	Addressed in 08.04.	
12.6.3.5	For expedited service authorization decisions where a provider indicates, or the CCN 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 CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than seventy-two (72) hours after receipt of the request for service.	Full	Addressed in 08.04.	
12.6.3.6	The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or provider acting on behalf of the member requests an extension, or if the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	Addressed in 08.04.	
12.6.3.7	DHH may conduct random reviews to ensure that members are receiving such notices in a timely	N/A		

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	manner.			
12.7	**Continuation of Benefits While the State Fair Hearing Is Pending**			
12.7.1	If the enrollee requests a hearing before the date of action or within ten (10) days from the postmark of the notice, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:	Non-Compliance (determination changed to Full)	State Fair Hearing Policy doesn't indicate that the plan cannot terminate or reduce services until a decision is rendered if an enrollee requests a hearing within the timeframe noted in the contract.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal process. IPRO response: Based on a re-review of the member handbook, determination changed to "Full."
12.7.1.1	It is determined that the sole issue is one of Federal/state law or policy; and	Non-Compliance (determination changed to Substantial)	State Fair Hearing Policy doesn't address Federal/state law or policy.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal process. IPRO response:

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				Based on a re-review of the member handbook, determination changed to "Substantial." It is recommended that the policy specify "federal/state law or policy."
12.7.1.2	The agency promptly informs the recipient in writing that services are to be terminated/reduced pending the hearing decision.	Non-Compliance (determination changed to Substantial)	State Fair Hearing Policy does not specify that the plan will promptly inform members in writing that services are to be terminated/reduced pending the hearing decision.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal process. IPRO response: Based on a re-review of the member handbook, determination changed to "Substantial." It is recommended that the policy specifically mention that CHS will promptly notify members.
12.7.2	Member Responsibility for Services Furnished While the State Fair Hearing is Pending - If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the State 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.	Non-Compliance (determination changed to Full)	Member's responsibility for cost of service in the event that the decision is adverse to the member is not included in the plan's policy.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				process. IPRO response: Based on a re-review of the member handbook, determination changed to "Full."
12.8	**Information about the Grievance System to Providers and Contractors**			
12.8.0	The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract as specified in this RFP.	Full	Evidenced in the Provider Manual.	
12.9	**Recordkeeping and Reporting Requirements**			
12.9.0	Reports of grievances and resolutions shall be submitted to DHH. The CCN shall not modify the grievance procedure without the prior written approval of DHH.	Full	Grievance summary reports and logs are prepared and were reviewed.	
12.10	**Effectuation of Reversed Decision Resolutions**			
12.10.0	If the CCN or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the State Fair Hearing was pending, the CCN must authorize the disputed services promptly, and as expeditiously as the member's health condition requires.	Non-Compliance	Notation that the plan will promptly authorize services as necessary when the State Fair Hearing Officer reverses a decision doesn't appear in policy.	MCO response: Completed. While the information had been published, Per Member Handbook (p.12): When you ask for a State Fair Hearing, your benefits will continue to the level of care you were receiving prior to your request for a hearing. If the final hearing decision is not in your favor, you may be asked to pay for benefits you received while you were waiting for your Fair Hearing decision", CHS has additionally added the policy statement to the template for correspondence regarding State Fair Hearing/Appeal process.

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				IPRO response: Determination is unchanged. Policy should state that services will be authorized as necessary when a decision is reversed.

Reporting Requirements				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
16	**Reporting Requirements**			
16.1	The CCN is responsible for complying with all the reporting requirements established by DHH.	N/A		
16.3	The CCN shall create reports or files (known as Deliverables) using the formats, including electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the format must be approved by DHH prior to implementation. The CCN shall provide to DHH and any of its designee's copies of reports generated by the CCN concerning CCN members and any additional reports requested by DHH or its designee in regard to performance of the Contract.	Full	Reporting Spreadsheet provided includes monthly, quarterly and annual timelines and lists, by report, report # and name, owner(s), attester and date of submission to DHH. A similar format is used for financial reporting. CHS has a newly created policy, INT 08.09 CHS-LA DHH Reporting that details the process by which reports are tracked, collected and submitted.	
16.4	DHH will provide the CCN with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reports shall be submitted in accordance with the schedule outlined in this RFP. In the event that there are no instances to report, the CCN shall submit a reporting stating so.	Full	Copies of submitted reports provided	
16.5	The CCN shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, claims pre-processed and other information as specified within this	Full	Reports include evidence of attestation.	

Reporting Requirements				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.			
16.5.1	The data shall be certified by one of the following: (1) CCN's Chief Executive Officer (CEO); (2) CCN's Chief Financial Officer (CFO); or (3) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO	Full	Reports include evidence of attestation.	