Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.3	**Behavioral Health Services**			
6.3.1	The CCN shall strongly support the integration of both physical and behavioral health services through screening and strengthening prevention/early intervention at the PCP level of care. The PCP shall collaborate with behavioral health specialists, including but not limited to, psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, 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.	Full	Policy LA UM.01 Utilization Management Program Description addresses requirement.	
6.3.4	Basic Behavioral Health Services	N/A		
6.3.4.1	The CCN shall be responsible for providing basic behavioral health benefits and services to all members. Basic behavioral health services may further be defined as those provided in the member's PCP or medical office by the member's (non-specialist) physician (i.e., DO, MD, ARNP) as part of routine physician evaluation and management activities, and all behavioral health services provided at FQHCs/RHCs). The CCN shall	Full	Addressed in Member Handbook (Medicaid Covered Services), and Provider Manual – Services are not provided by the plan directly and are carved out to Magellan Behavioral Health Services.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	utilize the screening tools and protocols approved by DHH. The CCN shall be required to work with PCPs to implement screening tools for basic behavioral health, such as the Patient Health Questionnaire, (PHQ-9) and the Pediatric Symptom Checklist (PSC, Y-PHC), which are subject to approval by DHH.			
6.3.4.2	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; 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. Medical services to be covered by the CCN include the following, but are not limited to: inpatient hospital services based on medical necessity, including: Acute Medical	Full	Addressed in the Provider Manual and Member Handbook.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	Detoxification providing 24-hour availability of non-surgical medical treatment for acute intoxication and/or life threatening conditions, under the direction of a physician in a hospital or other suitably equipped medical setting, with continuous services to persons afflicted with an alcohol and/or drug related crisis. In addition to having a physician's direction, one registered nurse or one licensed practical nurse must be on duty 24 hours per day for every 10 patients.			
6.7	**Emergency Medical Services and Post Stabilization Services**			
6.7.1	Emergency Medical Services	N/A		
6.7.1.1	The CCN shall provide that emergency services be rendered without the requirement of prior authorization of any kind. The CCN must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the CCN. If an emergency medical condition exists, the CCN is obligated to pay for the emergency service.	Full	Addressed in Policy LA UM12 Emergency and Post Stabilization Services.	
6.7.1.2	The CCN shall advise all Medicaid CCN members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Full	Addressed in Provider Manual and Member Handbook.	
6.7.1.3	The CCN shall not refuse to cover emergency services based on the emergency room provider, hospital,	Full	Addressed in Policy LA UM12 Emergency and Post Stabilization Services.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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 fiscal agent not notifying the member's PCP or CCN of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.			
6.7.1.4	The CCN shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Full	Addressed in Policy LA UM12 Emergency and Post Stabilization Services.	
6.7.1.5	The CCN shall not deny payment for treatment obtained when a member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition.	Full	Addressed in Policy LA UM12 Emergency and Post Stabilization Services.	
6.7.1.6	The attending emergency physician or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the CCN for coverage and payment.	Full	Addressed in Policy LA UM12.	
6.7.1.7	If there is a disagreement between a hospital or other treating facility and a CCN concerning whether the member is stable enough for discharge or transfer from the emergency room, the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the CCN. This subsection shall not apply to a disagreement	Full	Addressed in Policy LA UM12.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	concerning discharge or transfer following an inpatient admission once the member is stabilized.			
6.7.1.8	The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	Full	Addressed in Policy LA UM12.	
6.7.1.9	The CCN shall be responsible for educating members and providers regarding appropriate utilization of emergency room services, including behavioral health emergencies.	Full	Addressed in Policy LA UM12.	
6.7.1.10	The CCN shall monitor emergency services utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is: a person who possesses an average knowledge of health and medicine.	Full	Policy CC.CM.05 Emergency Department Diversion addresses emergency services utilization. Policy LA UM12 Emergency and Post Stabilization Services addresses prudent layperson requirement	
6.7.1.11	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Full	Addressed in LA UM12.	
6.7.2	Post Stabilization Services	N/A		
6.7.2.1	The CCN is financially responsible for post-stabilization care services	Full	Addressed in LA UM12.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	obtained within or outside the CCN that are:			
6.7.2.1.1	Pre-approved by a network provider or other CCN representative; or	Full	Addressed in LA UM12.	
6.7.2.1.2	Not preapproved by a network provider or other CCN representative, but:	Full	Addressed in LA UM12.	
6.7.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the CCN for pre-approval of further post-stabilization care services;	Full	Addressed in LA UM12.	
6.7.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the CCN: • Does not respond to a request for pre-approval within one (1) hour; • Cannot be contacted; or • CCN's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the CCN must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of Section 6.7.2.1.4.1 (422.133(c)(3)) is met.	Full	Addressed in Policy UM 12 Emergency and Post Stabilization Programs.	
6.7.2.1.3	The CCN's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.7.2.1.3.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	Full	Addressed in Policy UM 12.	
6.7.2.1.3.2	A network physician assumes responsibility for the member's care through transfer;	Full	Addressed in Policy UM 12.	
6.7.2.1.3.3	A representative of the CCN and the treating physician reach an agreement concerning the member's care; or	Full	Addressed in Policy UM 12.	
6.7.2.1.3.4	The member is discharged.	Full	Addressed in Policy UM 12.	
6.16	**Medical Services for Special Populations**			
6.16.1	Special health care needs population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches.	Full	Addressed in Policy LA CM 02 Chronic Care Management Programs and also addressed in Attachment A (Complex Case Management) to Policy LA CM01.	
6.16.2	The CCN shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). 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. Assessments that determine a course of treatment or	Full	Addressed in Policy LA CM 01 Case Management.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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 as appropriate shall result in a referral for case management. During the initial phase-in implementation of the CCN Program, DHH will extend the identification timeframe requirement to 180 days from the enrollment effective date.			
6.16.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows:	N/A		
6.16.3.1	The CCN shall utilize Medicaid historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for SHCN criteria.	Full	Addressed in Policy CM 01 Case Management Case Management Program Description.	
6.16.3.2	The CCN PCPs shall identify to the CCN those members who meet SHCN criteria.	Full	Addressed in Policy CM01.	
6.16.3.3	Members may self identify to either the Enrollment Broker or the CCN that they have special health care needs. The Enrollment Broker will provide notification to the CCN of members who indicate they have special health care needs.	Full	The plan's Case Management Report (PQ039) clearly indicates the number of members self declared with special care needs. There is no report generated by the enrollment broker to the plan indicating the number of members with special health care needs, nor any documentation to indicate that the enrollment broker is capturing these data for the plan. The plan furnished a report from the enrollment broker (Maximus) indicating the number of members transferring in and out of the plan, but not members identified with special care needs. It is recommended that the plan determine if the enrollment broker is in fact capturing these members, and if so, modify reporting to capture these data.	
6.16.4	Individualized Treatment Plans	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.16.4.1	The individual treatment plans must be: developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member;	Full	Addressed in Policy LA CM01 Case Management Program Description.	
6.16.4.2	Approved by the CCN in a timely manner if required by the CCN; and	Full	Addressed in Policy LA CM01 Case Management Program Description.	
6.16.4.3	In compliance with applicable QA and UM standards.	Full	Addressed in Policy LA CM01 Case Management Program Description.	
6.24	**Care Management**			
6.24.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, quality 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 covered services provided to the member.	Full	Addressed in Policy LA CM01 Case Management Program Description.	
6.24.2	The CCN shall be responsible for ensuring:	N/A		
6.24.2.1	Member's health care needs and services/care are planned and coordinated through the CCN PCP;	Full	Addressed in Policy LA CM01 Case Management Program Description.	
6.24.2.2	Accessibility of services and promoting prevention through qualified medical home practices which requires the provision for reasonable and adequate hours of operation including 24 hour	Full	Addressed in Policy LA UM 01 Utilization Management Program Description.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	availability of information, referral, and treatment for emergency medical conditions; and			
6.24.2.3	Care coordination and referral activities incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.	Full	Addressed in Policy LA CM01 and LA CM 01.02 Care Plan Development and Implementation.	
6.25	**Referral System for Specialty Healthcare**			
6.25.1	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. The CCN shall provide the coordination necessary for referral of CCN members to specialty providers. 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. The referral system must include processes to ensure monitoring and documentation of specialty health care and out-of-network referrals, services (*e.g.*, medications prescribed, treatment received, recommendations for care), and follow up are included in the PCP's member medical record.	Full	Addressed in Policy LA UM 16.01 Referrals to Specialty Healthcare Services.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.25.2	The CCN shall submit referral system policies and procedures for review and approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following elements:	N/A		
6.25.2.1	When a referral from the member's PCP is and is not required;	Full	Addressed in Policy LA UM 16.01 Referrals to Specialty Healthcare Services.	
6.25.2.2	Process for member referral to an out-of-network provider when there is no provider within the CCN's provider network who has the appropriate training or expertise to meet the particular health needs of the member;	Full	Addressed in Policy LA UM 16.01.	
6.25.2.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Full	Addressed in Policy LA UM 16.01.	
6.25.2.4	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 LA UM 16.01.	
6.25.2.5	Process for member referral for case management;	Full	Addressed in Policy LA UM 16.01.	
6.25.2.6	Process for member referral for chronic care management;	Full	Addressed in Policy LA UM 16.01.	
6.25.2.7	Policy that prohibits providers from making referrals for designated	Full	Addressed in Policy LA UM 16.01.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.			
6.25.2.8	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 LA UM.06 Clinical Information and Documentation Policy UM 16.01 Referrals to Specialty Health Care Services Physician /Clinic Medical Record Review Tool	
6.25.2.9	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 communication of patient information between the specialty health care provider and the primary care provider; and	Full	Addressed in Policy UM 16.	
6.25.2.10	Process for referral of members for Medicaid State Plan services that are excluded from CCN core benefits and services and that will continue to be provided through fee-for-service Medicaid.	Full	Addressed in Policy LA UM 16.01.	
6.25.2.11	DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems.	N/A		
6.26	**Care Coordination, Continuity of Care, and Care Transition**			
6.26.1	The CCN shall develop and maintain effective care coordination, continuity of care, and care	Full	Addressed in Policy LA UM 16 Continuity and Coordination of Services.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	transition activities to 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 core benefits and services with services that are reimbursed on a fee-for-service basis by DHH. 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.			
6.26.2	The CCN shall be responsible for the coordination and continuity of care of healthcare services for all members.	Full	Addressed in Policy LA UM 16.	
6.26.3	The CCN shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:	N/A		

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.26.3.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Full	Addressed in Policy LA UM 16.	
6.26.3.2	Coordinate care between PCPs and specialists;	Full	Addressed in Policy LA UM 16. File review demonstrated care coordination between PCPs and specialists.	
6.26.3.3	Coordinate care for out-of-network services, including specialty care services;	Full	Addressed in Policy LA UM 16. File review demonstrated appropriate care coordination for out of network services.	
6.26.3.4	Coordinate CCN provided services with services the member may receive from other health care providers;	Full	Addressed in Policy LA UM 16. File review demonstrated care coordination with other health care providers.	
6.26.3.5	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 LA UM 16.	
6.26.3.6	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, and other applicable state or federal laws;	Full	Addressed in Policy LA UM 16.	
6.26.3.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Full	Addressed in Policy LA UM 16.03 Continued Stay and Discharge Planning Review.	
6.26.3.8	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate;	Full	Addressed in Policy LA UM 16.03.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.26.3.9	Identify members using emergency department services inappropriately to assist in scheduling follow-up care with PCP and/or appropriate specialists;	Full	Addressed in Policy LA UM 01 Utilization Management Program Description Coordination between Providers.	
6.26.3.10	Document authorized referrals in its utilization management system;	Full	Addressed in Policy LA UM01.	
6.26.3.11	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.	Full	Addressed in Policy LA UM.16.	
6.30	**Continuity for Behavioral Health Care**			
6.30.1	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 LA UM .01 Utilization Management Program Description.	
6.30.2	In order to ensure continuity and coordination of care for members who appear to need 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	Full	Addressed in Policy LA UM .01.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	responsible for specialized behavioral health services (as applicable) for services.			
6.30.3	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. Payment for the emergency service is the responsibility of the CCN.	Full	Addressed in Member Handbook.	
6.30.4	The CCN shall comply with all post stabilization care service requirements.	Full	Addressed in Policy LA UM 12 Emergency and Post Stabilization Requirements.	
6.30.5	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 LA UM 16.01 Referrals to Specialty Health Care Services Specialty Behavioral Health Service.	
6.30.6	The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	Full	Addressed in Policy LA UM 16.01.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.30.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.	Substantial	Policy LA CM01 includes children with special healthcare needs under case management criteria, does not address co-occurring medical and behavioral health conditions.	MCO response: Health plan added required language to page 6 of policy LA.CM.01 IPRO response: No change in determination, but policy change is noted and will be reviewed as part of next year's audit.
6.30.8	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 LA UM 16.01.	
6.32	**Care Transition**			
6.32.1	Provide active assistance to members when transitioning to another provider (CCN, or Medicaid FFS).	Full	Addressed in Policy LA UM16.	
6.32.2	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 (i.e. prenatal care, acute care, etc.). 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, but not limited to, 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	Full	Addressed in Policy LA UM16.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	services (if applicable) and all other requirements for new members.			
6.32.3	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 of the beginning of the month that the new CCN member enrollment is effective.	Full	Addressed in Policy LA UM 16.	
6.32.4	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 documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.	Full	Addressed in Policy LA UM 16.	
6.32.5	Appropriate medical records and	Full	Addressed in Policy LA UM 16.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	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.			
6.32.6	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 LA UM 16.	
6.32.8	Special consideration should be given to, but not limited to, the following:	N/A		
6.32.8.1	Members with significant conditions or treatments such as enteral feedings, oxygen, wound care, and ventilators, medical supplies, transportation on a scheduled basis, chemotherapy and/or radiation therapy or who are hospitalized at the time of transition;	Full	Addressed in Policy LA UM 16.	
6.32.8.2	Members who have received prior authorization for services such as scheduled surgeries, post surgical follow up visits, therapies to be provided after transition or out-of-area specialty services;	Full	Addressed in Policy LA UM 16.	
6.32.8.3	Members who have conditions requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;	Full	Addressed in Policy LA UM 16.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.32.8.4	Members with significant medical conditions such as a high-risk pregnancy or pregnancy within the last 30 days, the need for organ or tissue transplantation, chronic illness resulting in hospitalization;	Full	Addressed in Policy LA UM 16.	
6.32.9	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 LA UM 16.	
6.33	**Case Management (CM)**			
6.33.1	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, social services, and basic behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs. The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a	Full	Addressed in Policy LA CM01 Case Management.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, social and behavioral health needs of the member. The CCN shall submit case management program policies and procedures to DHH for approval within thirty (30) days following the date the contract is signed and annually thereafter.			
6.33.2	Case Management program functions shall include but not be limited to:	N/A		
6.33.2.1	Early identification of members who have or may have special needs;	Full	Addressed in Policy LA CM 01.	
6.33.2.2	Assessment of a member's risk factors;	Full	Addressed in Policy LA CM 01.	
6.33.2.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Full	Addressed in Policy LA CM 01.	
6.33.2.4	Development of an individualized treatment 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 Policy LA CM 01.	
6.33.2.5	Referrals and assistance to ensure timely access to providers;	Full	Addressed in Policy LA CM 01.	
6.33.2.6	Care coordination that actively links the member to providers, medical services, residential, social,	Full	Addressed in Policy LA CM 01.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	community and other support services where needed;			
6.33.2.7	Monitoring;	Full	Addressed in Policy LA CM 01.	
6.33.2.8	Continuity of care; and	Full	Addressed in Policy LA CM 01.	
6.33.2.9	Follow-up and documentation.	Full	Addressed in Policy LA CM 01.	
6.34	**Case Management (CM) Policies and Procedures**			
6.34.0	The CCN shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from the date the Contract is signed by the CCN, annually and previous to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:	Full	Addressed in Policy LA CM 01 Attachment A-Complex Case Management.	
6.34.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Full	Addressed in Policy LA CM 01.	
6.34.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Full	Addressed in Policy LA CM 01.	
6.34.3	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 Policy LA CM 01 and Policy LA CM 01 02 Care Plan Development and Implementation.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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;			
6.34.4	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Full	Addressed in Policy LA CM 01 02.	
6.34.5	Procedures and criteria for making referrals to specialists and subspecialists;	Full	Addressed in Policy LA UM 16.01 Referrals to Specialty HealthCare Services.	
6.34.6	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and	Full	Addressed in Policy LA CM 01 02.	
6.34.7	Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.	Full	Addressed in Policy LA CM 02 01 Coordination with Nurtur Disease Management Programs.	
6.35	**Case Management Reporting Requirements**			
6.35.0	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 due date of those reports. The case management reports shall include at a minimum:	Full	Case Management Report PQ039 –reported quarterly.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.35.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	Full	Case Management Report PQ039 –reported quarterly.	
6.35.2	Number of members with special healthcare needs identified by the member's PCP;	Full	Case Management Report PQ039 –reported quarterly.	
6.35.3	Number of members with assessments;	Full	Addressed in Assessment Summary Report.	
6.35.4	Number of treatment plans completed, and	Non-Compliance	Case Management Reports (PQ039) and Assessment Summary Reports provided did not include a breakdown of treatment plans completed. The Annual Quality Assessment and Performance Improvement Program Evaluation Report included a discussion of case management programs but treatment plan data was not included. It is recommended that reporting be revised to include these data.	MCO response: A summary of the CM treatment plan data will be added to the QAPIC Program Evaluation Summary for 2013 and going forward. Compliance requested meeting with Corporate office to update PQ039 report to include treatment plan data. Will be implemented by Q1 2014. IPRO response: No change in determination, but planned updates will be reviewed as part of next year's audit.
6.35.5	Number of members with assessments resulting in a referral for Case Management.	Full	Addressed in Case Management Report PQ 039.	
6.36	**Chronic Care Management Program (CCMP)**			
6.36.1	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 LA CM 02 Chronic Care Disease Management Programs.	
6.36.2	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;	Full	Addressed in Policy LA CM 02.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	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.			
6.36.3	The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The CCN shall develop and implement policies and procedures that:	N/A		
6.36.3.1	Include the definition of the target population;	Full	Addressed in Policy LA CM 02.	
6.36.3.2	Include member identification strategies;	Full	Addressed in Policy LA CM 02.	
6.36.3.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Full	Addressed in Policy LA CM 02.	
6.36.3.4	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 LA CM 02.	
6.36.3.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Full	Addressed in Policy LA CM 02.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
6.36.3.6	Include methods for informing and educating members and providers;	Full	Addressed in Policy LA CM 02.	
6.36.3.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in Policy LA CM 02.	
6.36.3.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in Policy LA CM 02.	
6.36.3.9	Address co-morbidities through a whole-person approach;	Full	Addressed in Policy LA CM 02.	
6.36.3.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Full	Addressed in Policy LA CM 02.	
6.36.3.11	Include Program Evaluation requirements.	Full	Addressed in Policy LA CM 02.	
6.37	**Predictive Modeling**			
6.37.1	The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.	Full	Addressed in Policy LA CM 06 Predictive Modeling Methodology.	
6.37.2	The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines within thirty (30) days of signing the Contract and annually thereafter and prior to any changes. These specifications shall include but are not limited to:	Full	Addressed in Policy LA CM 06 Predictive Modeling Methodology.	
6.37.2.1	A brief history of the tool's development and historical and	Full	Addressed in Guide for Predictive Modeling and Policy LA CM 06.	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	current uses;			
6.37.2.2	Medicaid data elements to be used for predictors and dependent measure(s);	Full	Addressed in Policy LA CM 06.	
6.37.2.3	Assessments of data reliability and model validity;	Full	Addressed in Policy LA CM 06.	
6.37.2.4	A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and	Full	Addressed in Policy LA CM 06.	
6.37.2.5	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 Policy LA CM 06.	
6.38	**CCMP Reporting Requirements**			
6.38.1	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.	Full	Addressed in Chronic Care Management Program Summary Report (PQ042 Report).	
6.38.2	The CCMP reports shall contain at a minimum:	N/A		
6.38.2.1	Total number of members;	Full	Addressed in Chronic Care Management Program Summary Report (PQ042 Report).	
6.38.2.2	Number of members in each stratification level for each chronic condition; and	Full	Addressed in Chronic Care Management Program Summary Report (PQ042 Report).	
6.38.2.3	Number of members who were disenrolled from program and explanation as to why they were	Full	Addressed in Chronic Care Management Program Summary Report (PQ042 Report).	

Core Benefits & Services				
State Contract Requirements [Federal Regulation: 438.114, 438.208]	**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**
	disenrolled.			
6.38.3	The CCN shall submit the following report annually:	N/A		
6.38.3.1	Program evaluation.	Full	Addressed in Policy LA CM 02 –Chronic Care Management Program-Discussion of Outcomes Measurement.	

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**
7.1	**General Provider Network Requirements**			
7.1.1	The CCN must maintain a network of qualified providers in sufficient numbers and locations within the GSA, including parishes contiguous to the GSA, to provide required access to covered services. 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. The CCN shall design their provider networks to maximize the availability of community based primary care and specialty care access and that reduces utilization of emergency services, one day hospital admissions, hospital based outpatient surgeries when lower cost surgery centers are available, eliminates preventable hospital readmissions, and hospitalization for preventable medical problems.	Full	Addressed in the Network Provider Development and Management Plan.	
7.1.2	The CCN must provide a comprehensive network to ensure its membership has access at least equal to, or better, than community norms. 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	Full	Addressed in the Network Provider Development and 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**
	GSA who are not enrolled in the CCN Program. The CCN is encouraged to have available non-emergent after-hours physician or primary care services within its network. 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. The CCN shall ensure coordination with respect to authorization and payment issues in these circumstances.			
7.1.3	There shall be sufficient personnel for the provision of all covered services, including emergency medical care on a 24-hour-a-day, 7-day-a-week basis.	Full	Addressed in LA.CONT.01 Network Adequacy.	
7.1.4	The proposed network shall be sufficient to provide core benefits and services within designated time and distance limits.	Full	Addressed in Network Development and Management Plan.	
7.1.5	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 agreement.	
7.1.6	If a current Medicaid provider requests participation in a CCN, the CCN shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not	Full	Addressed in Network Development and 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**
	participate in the CCN, the CCN has met this requirement; the CCN shall maintain documentation detailing efforts made.			
7.1.7	The CCN shall not discriminate with respect to participation in the CCN program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification. In addition, the CCN must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment.	Full	Addressed in Network Development and Management Plan.	
7.1.8	The provision in 7.1.6 above does not prohibit the CCN from limiting provider participation to the extent necessary to meet the needs of the CCN's members. This provision also does not interfere with measures established by the CCN to control costs and quality consistent with its responsibilities under this contract nor does it preclude the CCN from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty.	Full	Addressed in Network Development and Management Plan.	
7.1.9	The CCN shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be reached and a STP does	Full	LA CONT.02 and the Network Development and Management Plan address this requirement.	

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**
	not participate in the CCN, the CCN shall maintain documentation detailing efforts that were made.			
7.1.10	The CCN must offer a Contract to the following providers: Louisiana Office of Public Health (OPH); all OPH-certified School Based Health Clinics (SBHCs) in the GSA; all small rural hospitals in the GSA meeting the definition in the Rural Hospital Preservation Act of 1997; Federally Qualified Health Centers (FQHCs); Rural Health Clinics (RHCs) (free-standing and hospital based); and Louisiana State University safety net hospitals.	Full	Addressed in Network Development and Management Plan.	
7.1.11	If the CCN declines requests of individuals or groups of providers to be included in the CCN network, the CCN must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision.	Full	Addressed in Network Development and Management Plan.	
7.1.12	If the CCN terminates a provider's contract for cause, the CCN shall provide immediate written notice to the provider. The CCN shall notify DHH of the termination as soon as possible, but no later than seven (7) calendar days, of written notification of cancelation to the provider.	Full	LA.PRVR.23 Provider Termination Policy addresses notification of DHH. CC.CRED.10 Practitioner Disciplinary Action and Reporting addresses provider notification.	
7.1.13	The CCN shall make a good faith effort to give written notice of termination of a contracted	Full	Addressed in LA.MBRS.27 Member Advisory of Provider Termination.	

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**
	provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider.			
7.1.15	The CCN shall meet the following requirements:	N/A		
7.1.15.1	Ensure the provision of all core benefits and services specified in the Contract. Accessibility of benefits/services, including geographic access, appointments, and wait times shall be in accordance with the requirements in this RFP. These minimum requirements are not intended to release the CCN from the requirement to provide or arrange for the provision of any medically necessary covered benefit/service required by its members, whether specified or not.	Full	Addressed in the Provider Manual.	
7.1.15.2	Provide core services directly or enter into written agreements with providers or organizations that shall provide core services to the members in exchange for payment by the CCN for services rendered. CCN in and out-of-network providers shall be eligible to enroll as Louisiana Medicaid providers.	Full	Provider agreements for ancillary services, clinic, group and hospitals provided.	
7.1.15.3	Not execute contracts with individuals or groups of providers who have been excluded from	Full	Addressed in CC.CRED.04 Initial Credentialing Process. Credentialing file review demonstrated evidence of screening applicants for exclusions.	

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**
	participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/search.aspx and www.EPLS.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.			
7.1.15.4	Ensure that CCN PCP's maintain hospital admitting privileges or that they have arrangements with a physician who has admitting privileges at a CCN participating hospital.	Full	Addressed in CC.CRED.04 Initial Credentialing Process.	
7.1.15.5	Not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Members health status, medical or behavioral health care, or treatment options, including any alternative treatment that may be self administered; information the member needs in order to decide among all relevant treatment options; the risk, benefits, and consequences of treatment and non-treatment; or the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express	Full	Addressed in Provider Agreement.	

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**
	preferences about future treatment decisions.			
7.1.15.6	If the CCN is unable to meet the geographic access standards for a member, the CCN must make transportation available to the member, regardless of whether the member has access to transportation.	Full	Addressed in LA.CONT.03 Access to Transportation.	
7.1.15.7	Monitor provider compliance with applicable access requirements, including but not limited to, appointment and wait times, and take corrective action for failure to comply. The CCN shall conduct service area review of appointment availability and twenty-four (24) hour access and availability surveys annually. The survey results must be kept on file and be readily available for review by DHH upon request.	Minimal	Addressed in Provider Manual. LA.PRVR.04 Provider Appointment Accessibility Standards addresses monitoring of provider compliance with appointment standards. Monitoring includes routine office visits by provider relations staff and phantom calls to assess appointment availability, hours of operation and 24/7 availability. Evidence of monitoring provided: A spreadsheet titled PCP After-Hours Survey: July/August 2012 was provided. Appears to be a one-time survey. The data is not summarized and there is no indication that any f/u actions were taken in response to the findings. LHC PCP After-Hours Practice Response Time to Member Calls for Appointment dated 7/30/13 provided. This document showed 66 of 183 practices contacted as compliant, or 36.07% (practices contacted returned calls within 30 minutes). F/U actions not evident. Per LHC, a new process was recently implemented. LHC provided a document entitled Provider Access Standards and Monitoring: Hours of Operation and Appointment Availability (undated). Effective 9/1/13, monitoring includes phantom calls through a random sample of PCPs on a quarterly basis, and assessment of	MCO response: All measures being monitored as required by LA.PRVR.04 will be summarized in a scorecard and presented quarterly to the Performance Improvement Committee (PIT). Those providers who are not compliant will be identified and monitored for the following quarter. A collaborative review of the data will be scheduled with the non-compliant providers for discussion and development of an action plan to improve the measures over the next quarter. The provider's progress will be monitored on a monthly basis with updated results reported at the quarterly PIT meetings. The information and progress reported in this meeting is included as an update in the QAPIC quarterly meeting as well as in the annual program evaluation. IPRO response: No change in determination, but as noted by LHC, a new monitoring process was implemented in September 2013, beyond the scope of this audit. The new process will be reviewed as part of next year's audit.

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**
			appointment availability standards conducted during provider relations field visits. A template letter providing results to practices was provided. With the exception of after-hours monitoring, LHC did not provide evidence of monitoring for appointment availability and wait times.	
7.1.15.8	If a member requests a CCN provider who is located beyond access standards, and the CCN has an appropriate provider within the CCN who accepts new patients, it shall not be considered a violation of the access requirements for the CCN to grant the member's request. However, in such cases the CCN shall not be responsible for providing transportation for the member to access care from this selected provider, and the CCN shall notify the member in writing as to whether or not the CCN will provide transportation to seek care from the requested provider.	Full	Addressed in LA.CONT.03 Access to Transportation.	
7.1.15.9	The CCN shall require that providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters.	Full	Provider agreement addresses provision of language assistance, free of charge, for members with limited English skills. Also addressed in the Provider Manual.	
7.1.15.10	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. Failure to do	Full	Addressed in LA.CONT.02 Network Selection and Retention.	

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**
	so may result in monetary penalties up to $5,000 per day against the CCN.			
7.2	**Mainstreaming**			
7.2.1 [updated 9/8/11]	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 CCN providers do not intentionally segregate members in any way from other persons receiving services.	Full	Addressed in Provider Manual.	
7.2.2	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:	Full	Addressed in Provider Manual.	
7.2.2.1	Denying or not providing to a member any covered service or availability of a facility.	Full	Addressed in Provider Manual.	
7.2.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that	Full	Addressed in Provider Manual.	

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**
	provided to other members, other public or private patients, or the public at large.			
7.2.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Full	Addressed in Provider Manual.	
7.2.3	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 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.	Full	Addressed in LA.CONT.02.	
7.3	**Access Standards and Guidelines**			
7.3	The CCN shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hours care) in accordance with the provision of services under this RFP. DHH will monitor the CCN's	Full	Addressed in Network Development and Management Plan and LA.PRVR.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**
	service accessibility. The CCN shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional, allied and para-medical personnel for the provision of core benefits and services, including all emergency services, and shall take corrective action if there is failure to comply by any provider. At a minimum, this shall include:			
7.3.1	Twenty-four (24) Hour Coverage: The CCN shall ensure that all emergency medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct CCN members on where to receive emergency and urgent health care. The CCN may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. Any triage system arrangement must be prior approved by DHH.	Full	Addressed in Network Development and Management Plan and Provider Manual.	
7.3.2	Travel Time and Distance: 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 of prevailing community standards	Full	Addressed in Network Development and Management Plan and Geo Access reports.	

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**
	must be submitted in writing to DHH for approval.			
7.3.2.1	Time and Distance 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 10 miles	Full	Addressed in Network Development and Management Plan.	
7.3.2.2	Time and Distance to Hospitals. For urban areas, within thirty (30) minutes of a member's residence. For rural areas, within thirty (30) miles. If no hospital is available within thirty (30) miles of a member's residence, the CCN may request, in writing, an exception to this requirement.	Full	Addressed in Network Development and Management Plan.	
7.3.2.3	Time and Distance to Specialists. Travel distance shall not exceed sixty (60) miles for at least 75% of members. Travel distance shall not exceed ninety (90) miles for all members. Access standards to specialists that cannot be met may be satisfied utilizing telemedicine with prior DHH approval.	Full	Addressed in Network Development and Management Plan.	
7.3.2.4	Time and Distance to Lab and Radiology Services. Travel distance shall not exceed thirty (30) minutes or thirty (30) miles. For rural areas, exceptions for community standards shall be justified, documented and submitted to DHH for approval. Other medical service providers participating in the CCN's	Full	Addressed in LA.CONT.01 Network Adequacy.	

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**
	network also must be geographically accessible to CCN members as outlined in this RFP.			
7.4	**Scheduling/Appointment Waiting Times**			
7.4.1	The CCN shall ensure that its network providers have an appointment system for core benefits and services and/or expanded services which are in accordance with prevailing medical community standards as specified below.	Full	Addressed in Network Development and Management Plan and LA.PRVR.04 Provider Appointment Accessibility Standards.	
7.4.2	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 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.	Minimal	Addressed in Provider Manual. LA.PRVR.04 Provider Appointment Accessibility Standards addresses monitoring of provider compliance with appointment standards. Monitoring includes routine office visits by provider relations staff and phantom calls to assess appointment availability, hours of operation and 24/7 availability. Evidence of monitoring provided: A spreadsheet titled PCP After-Hours Survey: July/August 2012 was provided. The data is not summarized and there is no indication that any f/u actions were taken in response to the findings. LHC PCP After-Hours Practice Response Time to Member Calls for Appointment dated 7/30/13 provided. This document showed 66 of 183 practices contacted as compliant, or 36.07% (practices contacted returned calls within 30 minutes). F/U actions not evident. Per LHC, a new process was recently implemented. LHC provided a document entitled Provider Access Standards and Monitoring: Hours of Operation and	MCO response: All measures being monitored as required by LA.PRVR.04 will be summarized in a scorecard and presented quarterly to the Performance Improvement Committee (PIT). Those providers who are not compliant will be identified and monitored for the following quarter. A collaborative review of the data will be scheduled with the non-compliant providers for discussion and development of an action plan to improve the measures over the next quarter. The provider's progress will be monitored on a monthly basis with updated results reported at the quarterly PIT meetings. The information and progress reported in this meeting is included as an update in the QAPIC quarterly meeting as well as in the annual program evaluation. IPRO response: No change in determination, but as noted by LHC, a new monitoring process was implemented in September 2013, beyond the scope of this audit. The new process will be reviewed as part of next year's audit.

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**
			Appointment Availability (undated). Effective 9/1/13, monitoring includes phantom calls through a random sample of PCPs on a quarterly basis, and assessment of appointment availability standards conducted during provider relations field visits. A template letter providing results to practices was provided.	
7.5	**Timely Access**			
7.5	The CCN shall ensure that medically necessary services are available on a timely basis, as follows:	N/A		
7.5.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Full	Addressed in provider agreement.	
7.5.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the CCN through other arrangements.	Full	Addressed in provider agreement.	
7.5.3	Non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	Full	Addressed in provider agreement.	
7.5.4	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the CCN mails the member's welcome packet: within their first trimester within fourteen	Full	Addressed in provider agreement.	

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**
	(14) days; within the second trimester within seven (7) days; within their third trimester within three (3) days; 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;			
7.5.5	Routine, non-urgent, or preventative care visits within six (6) weeks;	Full	Addressed in provider agreement.	
7.5.6	Specialty care consultation within one (1) month of referral or as clinically indicated;	Full	Addressed in provider agreement.	
7.5.7	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	Full	Addressed in provider agreement and Provider Manual.	
7.5.8	Follow-up visits in accordance with ER attending provider discharge instructions.	Full	Addressed in Provider Manual.	
7.5.9	In office waiting time for scheduled appointments should not routinely exceed forty-five (45) minutes, including time in the waiting room and examining room: Providers may be delayed when they "work in" urgent cases, when a serious problem is found with a previous patient, or when a previous patient requires more services or education than was described at the time the appointment was scheduled. If a provider is delayed, patients shall	Full	Addressed in Provider Manual.	

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**
	be notified immediately. If the wait is anticipated to be more than ninety (90) minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.			
7.5.10	The CCN shall monitor providers regularly to determine compliance with this Section through such methods as "mystery shopping" and staged scenarios in an effort to reduce the unnecessary use of alternative methods of access to care such as emergency room visits ; and take corrective action if there is a failure to comply.	Minimal	Per LA.PRVR.04 Provider Appointment Accessibility Standards, LHC monitors providers by: information gathered during routine visits by provider relations staff, and phantom calls to verify appointment availability, hours of operation and 24/7 service availability. This policy also states that the results are tracked and education/corrective action taken as indicated. See comments above under 7.4.2. Documents provided do not show evidence of monitoring for compliance with waiting times.	MCO response: All measures being monitored as required by LA.PRVR.04 will be summarized in a scorecard and presented quarterly to the Performance Improvement Committee (PIT). Those providers who are not compliant will be identified and monitored for the following quarter. A collaborative review of the data will be scheduled with the non-compliant providers for discussion and development of an action plan to improve the measures over the next quarter. The provider's progress will be monitored on a monthly basis with updated results reported at the quarterly PIT meetings. The information and progress reported in this meeting is included as an update in the QAPIC quarterly meeting as well as in the annual program evaluation. IPRO response: No change in determination, but as noted by LHC, a new monitoring process was implemented in September 2013, beyond the scope of this audit. The new process will be reviewed as part of next year's audit.
7.5.11	The CCN must use the results of appointment standards monitoring	Minimal	As noted previously, LHC PCP After-Hours Practice Response Time to Member Calls for Appointment dated	MCO response: All measures being monitored as required by

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 assure adequate appointment availability in order to reduce unnecessary emergency department utilization. The CCN is also encouraged to contract with or employ the services of non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.		7/30/13 was provided. This document showed 66 of 183 practices contacted as compliant, or 36.07% (practices contacted returned calls within 30 minutes). Evidence of follow-up was not provided. The new process for monitoring compliance with appointment standards includes notification to providers and re-assessment of providers not meeting standards.	LA.PRVR.04 will be summarized in a scorecard and presented quarterly to the Performance Improvement Committee (PIT). Those providers who are not compliant will be identified and monitored for the following quarter. A collaborative review of the data will be scheduled with the non-compliant providers for discussion and development of an action plan to improve the measures over the next quarter. The provider's progress will be monitored on a monthly basis with updated results reported at the quarterly PIT meetings. The information and progress reported in this meeting is included as an update in the QAPIC quarterly meeting as well as in the annual program evaluation. IPRO response: No change in determination, but as noted by LHC, a new monitoring process was implemented in September 2013, beyond the scope of this audit. The new process will be reviewed as part of next year's audit.
7.5.12	The CCN shall establish processes to monitor and reduce the appointment "no-show" rate for PCPs, and transportation providers. As best practices are identified, DHH may require implementation by the CCN.	Full	Addressed in Provider Manual and QAPI Annual Evaluation.	
7.5.13	The CCN shall have written policies and procedures about educating its provider network about appointment time requirements. The CCN must develop a corrective action plan when appointment standards are not met. If appropriate, the corrective action plan should be developed in	Full	Addressed in Provider Manual.	

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**
	conjunction with the provider. Appointment standards shall be included in the Provider Manual. The CCN is encouraged to include the standards in the provider subcontracts.			
7.6	**Assurance of Adequate PCP Access and Capacity**			
7.6.1	The PCP shall serve as the member's initial and most important point of interaction with the CCN's provider network. A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in this Section.	Full	Addressed in Provider Manual.	
7.6.2	The PCP may practice in a solo or group practice or may practice in a clinic (i.e. Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)) or outpatient clinic. The CCN shall provide at least one (1) full time equivalent (FTE) PCP per two thousand, five hundred (2,500) CCN members. 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. The CCN shall require that each individual PCP shall not exceed a total of two thousand, five hundred (2,500) Medicaid linkages in all CCN's in which the PCP may be a network	Full	Addressed in Network Development and 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**
	provider.			
7.6.2.1	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: Physician (Family Practice, General Practice, Internal Medicine, Pediatric, OB/GYN) – 1 : up to 2,500	Full	Addressed in provider agreement. LA.QI.04 also addresses this requirement but states the acceptable ratio as 1:2,000. These documents should be consistent.	
7.6.2.2	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: Nurse Practitioner 1 : up to 1,000	Full	Addressed in LA.QI.04.	
7.6.2.3	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved by DHH: 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.	Full	Addressed in LA.QI.04.	
7.6.3	The CCN may submit a request for an exception to the PCP-to-patient ratio to DHH for approval.	N/A		
7.6.4	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.	Full	Addressed in the Member Handbook and Provider Manual.	

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**
7.6.5	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].	Full	Addressed in Network Development and Management Plan.	
7.6.6	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	Addressed in Provider Manual.	
7.6.7	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 LA.CONT.04 Timely Reporting of Closed Panels.	
7.7	**Primary Care Provider Responsibilities**			
7.7.0	PCP responsibilities shall include, but are not be limited to:	N/A		
7.7.1	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 Manual.	
7.7.2	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid. Coordination shall include but not be limited to:	Full	Addressed in Provider Manual.	
7.7.2.1	Referring patients to subspecialists	Full	Addressed in Provider Manual.	

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**
	and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available; and			
7.7.2.2	Communicate with other levels of care (primary care, specialty outpatient care, emergency and inpatient care) to coordinate, and follow up the care of individual patients.	Full	Addressed in Provider Manual.	
7.7.2.2.1	Provide the level of care and range of services necessary to meet the medical needs of its members, including those with special needs and chronic conditions,	Full	Addressed in the Provider Manual.	
7.7.2.2.2	Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment, to include services available under Medicaid FFS;	Full	Addressed in the Provider Manual.	
7.7.2.2.3	Maintaining a medical record of all services rendered by the PCP and other referral providers; and	Full	Addressed in the Provider Manual.	
7.7.2.2.4	Coordinating case management services to include, but not be limited to, performing screening and assessment, development of plan of care to address risks and medical needs.	Full	Addressed in the Provider Manual.	
7.7.2.2.5	Coordinate the services the CCN furnishes to the member with the services the member receives from any another CCN during transition	Full	Addressed in the Provider Manual.	

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**
	of care.			
7.7.2.2.6	Share the results of identification and assessment of any member with special health care needs (as defined by DHH) with another CCN to which a member may be transitioning or has transitioned so that those activities need not be duplicated.	Full	Addressed in the Provider Manual.	
7.7.2.2.7	To ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	Full	Addressed in the Provider Manual.	
7.7.2.3	Examples of Acceptable PCP After-Hours Coverage: 1. The PCP's office telephone is answered after-hours by an answering service that can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes. 2. 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. 3. The PCP's office	Full	Addressed in the Provider Manual.	

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**
	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.			
7.7.2.4	Examples of Unacceptable PCP After Hours Coverage: The PCP's office telephone is only answered during office hours. The PCP's office telephone is answered after-hours by a recording that tells patients to leave a message. The PCP's office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed. Returning after-hours calls outside of 30 minutes.	Full	Addressed in the Provider Manual.	
7.7.3	Access to Specialty Providers	N/A		
7.7.3.1	The CCN shall assure access to specialty providers, as appropriate, for all members. The CCN shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area. The CCN provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (e.g. a pediatric cardiologist). The CCN	Full	Addressed in Provider Manual, LA.CONT.01 and in Geo Access reports.	

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**
	shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.			
7.7.3.2	The CCN shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: the CCN has signed a contract with providers of the specialty types listed below who accept new members and are available on at least a referral basis; and the CCN is in compliance with access and availability requirements.	Full	Geo Access reports for Q2 dated 8/13 provided. Adequate access was demonstrated for most provider types and most geographic regions. Service Area C (regions 5, 6, 7, 8) showed access that falls below travel requirements across some provider types, most notably PCPs – pediatrics. This Area showed access at 73.3%. The statewide access for PCPs-pediatrics was 83.9%. Service Area C also shows lower access levels for PCPs Family Medicine/General Practice (86.9%), Nurse Practitioners (85.3%) and Internal Medicine (77.1%). The MCO notes a limited number of available providers in this area and continues efforts to recruit additional providers.	
7.7.3.3	The CCN shall assure, at a minimum, the availability of the following specialists and other providers, as appropriate for both adults and pediatric members, on at least a referral basis: See Provider Type check list at end of this document.	Full	Addressed in Network Development and Management Plan.	
7.7.3.4	The CCN shall meet standards for timely access to all specialists and ensure that the number of CCN members per specialist does not exceed the following in each of the CCN's GSAs. The following	Full	Addressed in Network Development and 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**
	provider/member ratios are the minimum the CCN must provide. The CCN will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by DHH the CCN does not meet the access standards (e.g. scheduling of appointment, timely access, time and travel distance requirements) specified in the Contract. See Maximum Number of Members per Provider by Specialty at end of this document.			
7.7.4	Access to Home Health Agencies: the CCN shall comply with any applicable federal requirements with respect to home health agencies, as amended.	Full	Addressed in LA.CONT.01.	
7.7.5	Access to Hospitals	N/A		
7.7.5.1	Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.	Full	Addressed in Network Development and Management Plan and LA.CONT.01.	
7.7.5.2	The CCN shall include, at a minimum, access to the following: one (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the GSA, provided the parish has such a hospital.	Full	Addressed in Network Development and 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**
	Essential hospital services for: Level III Obstetrical services; Level III Neonatal Intensive Care (NICU) services; Pediatric services; Trauma services; Burn services; and a Children's Hospital.			
7.7.5.3	The CCN may contract with out-of-state hospitals in the trade area.	Full	Addressed in LA.CONT.01.	
7.7.5.4	The CCN may contract with out-of-state hospitals to comply with these requirements if there are no hospitals within the parish that meet these requirements or a contract cannot be negotiated.	Full	Addressed in Network Development and Management Plan.	
7.7.6	Tertiary Care - Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists. These services frequently require complex technological and support facilities. The CCN shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the GSA. If the CCN does not have a full range of tertiary care services, the CCN shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.	Full	Addressed in Network Development and Management Plan.	
7.7.7	Direct Access to Women's Health Care - The CCN shall provide direct access to a health specialist(s) in-	Full	Addressed in Network Development and 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**
	network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.			
7.7.7.1	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 and interconception care services for members to optimize member health entering pregnancy.	Full	Addressed in Network Development and Management Plan and Member Handbook.	
7.7.7.2	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. 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.	Full	Addressed in Network Development and 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**
7.7.7.3	The CCN shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act, and shall reimburse providers for all family planning services regardless of whether that provider is a network provider no less than the Medicaid fee-for-service rate on date of service.	Full	Addressed in Network Development and Management Plan.	
7.7.7.4	Reimbursement to out-of-network providers of family planning services for members shall be no less than the Medicaid fee-for-service rate on date of service. The CCN may require family planning providers to submit claims or reports in specified formats before reimbursing services.	Full	Addressed in Network Development and Management Plan.	
7.7.7.5	The CCN shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	Full	Addressed by CC.COMP.04 Confidentiality and Release of Protected Health Information.	
7.7.8	Prenatal Care Services	N/A		
7.7.8.1	The CCN shall have a sufficient number of providers to ensure that prenatal care services are not delayed or denied to pregnant women.	Full	Demonstrated by Geo Access reports.	
7.7.8.2	Regardless of whether prenatal care is provided by a PCP, physician extender or an obstetrician who is not the member's PCP, the access	Full	Addressed in Network Development and 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**
	standards for PCP services shall apply when determining access to prenatal care except for cases of a first prenatal care appointment for women who are past their first trimester of pregnancy on the day they are determined to be eligible for Louisiana Medicaid. For women who are past their first trimester of pregnancy on the first day they are determined to be eligible, a first prenatal appointment shall be scheduled as required in 7.5.4.7.			
7.7.8.3	All pregnant members should choose a pediatrician, or other appropriate PCP, for the care of their newborn baby before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the CCN shall assign one. If the CCN was not aware that the member was pregnant until she presented for delivery, the CCN shall assign a pediatrician or a PCP to the newborn baby within one (1) business day after birth.	Full	Addressed in Member Handbook.	
7.7.9	Other Service Providers - The CCN shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with	Full	Addressed in Network Development and 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**
	applicable state and federal laws and regulations.			
7.7.10	Non-Emergency Medical Transportation - For medically necessary non-emergent transportation requested by the member or someone on behalf of the member, the CCN shall require its transportation provider to schedule the transportation so that the member arrives on time but no sooner than one hour before the appointment; nor have to wait more than one hour after the conclusion of the treatment for transportation home; nor be picked up prior to the completion of treatment.	Substantial	Addressed in LA.CONT.03. It is not evident how the transportation vendor is advised of these requirements. Not addressed in Transportation contract.	MCO response: NEMT transportation vendor will be formally notified of contract requirements, and documentation kept of such notification. Health plan will also work with corporate office on inclusion of these guidelines into the transportation contract. IPRO response: No change in determination. The transportation contract will be reviewed as part of next year's audit to ensure requirements are included.
	FQHC/RHC Clinic Services	N/A		
7.7.11.1	The CCN must offer to contract with all FQHCs and RHCs (both freestanding and hospital-based) in the GSA and include them in its provider network.	Full	Addressed in Network Development and Management Plan.	
7.7.11.2	If a CCN is unable to contract with an FQHC or RHC within the geographic service area and PCP time and distance travel standards, the CCN is not required to reimburse that FQHC or RHC for out-of-network services if FQHC or RHC services within Time and Distance to Primary Care Standards are available in that area unless: the medically necessary services are required to treat an emergency	Full	Addressed in LA.UM.01.01 Covered Benefits and Services.	

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**
	medical condition ; or FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the GSA within DHH's established time and distance travel standards.			
7.7.11.3	The CCN may stipulate that reimbursement will be contingent upon receiving a clean claim and all the medical records information required to update the member's medical records.	Full	Addressed in LA.UM.01.01 Covered Benefits and Services.	
7.7.11.4	While CCNs are not, in general, financially responsible for specialty behavioral health services, CCNs are responsible for all behavioral health services provided at FQHCs/RHCs.	Full	Addressed in LA.UM.01.01 Covered Benefits and Services.	
7.7.11.5	The CCN shall inform members of these rights in their member handbooks.	Full	Addressed in Member Handbook.	
7.7.11.6	The CCN shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from DHH.	Full	No evidence of entering into alternative reimbursement arrangements.	
7.7.12	School-Based Health Clinics (SBHCs)	N/A		
7.7.12.1	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	
7.7.12.2	The CCN must offer a contract to each SBHC in their GSA. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures	Full	Addressed in Network Development and 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**
7.7.13	Local Parish Health Clinics	N/A		
7.7.13.1	The CCN must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STD, family planning).	Full	Addressed in Network Development and Management Plan.	
7.7.13.2	The CCN shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCN.	Full	Addressed in LA.CONT.02.	
7.7.14	Significant Traditional Providers. 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 that the STP: agrees to participate as an in-network provider and abide by the provisions of the provider contract; and meets the credentialing requirements. Provider types/classes eligible for	Full	Addressed in Network Development and 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**
	participation as a STP are: Physicians, PCPs; OB-GYNs, and Hospitals.			
7.8	**Network Provider Development Management Plan**			
7.8.1	The CCN shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur. The Network Development and Management Plan shall be submitted to DHH within thirty (30) days from the date the CCN signs to contract with DHH for evaluation and approval, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the CCN's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the CCN shall consider the following:	Full	Addressed in Network Development and Management Plan.	
7.8.1.1	Anticipated maximum number of Medicaid members;	Full	Addressed in Network Development and Management Plan.	
7.8.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the CCN;	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.1.3	The numbers and types (in terms of	Full	Addressed in LA.CONT.02 Network Selection and	

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**
	training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;		Retention.	
7.8.1.4	The numbers of CCN providers who are not accepting new CCN members; and	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2	The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and shall include:	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2.1	Assurance of Adequate Capacity and Services	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2.2	Access to Primary Care Providers	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2.3	Access to Specialists	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2.4	Access to Hospitals	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.8.2.5	Timely Access	Full	Addressed in Network Development and Management Plan.	
7.8.2.6	Service Area	Full	Addressed in Network Development and Management Plan.	
7.8.2.7	Other Access Requirements: Direct	Full	Addressed in Network Development and Management	

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**
	Access to Women's Health, Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers.		Plan.	
7.8.3	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 Network Development and Management Plan.	
7.8.4	The CCN shall provide GEO mapping and coding of all network providers for each provider type to geographically demonstrate network capacity. The CCN shall provide updated GEO coding to DHH quarterly, or upon material change or upon request.	Full	Geo Access report for Q2 2013 provided.	
7.8.5	The CCN shall develop and implement Network Development policies and procedures detailing how the CCN will:	N/A		
7.8.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Full	Addressed in Network Development and Management Plan and LA.CONT.05.	
7.8.5.2	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	Full	Addressed in LA.CONT.05 Network Development & Management.	

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**
	compromised during the grievance/appeal processes;			
7.8.5.3	Evaluate the quality of services delivered by the network;	Full	Addressed in QAPI Program Evaluation.	
7.8.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Full	Addressed in Network Development and Management Plan.	
7.8.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	Full	Addressed in LA.CONT.05 and 2012 QAPI Program Evaluation.	
7.8.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	Full	Addressed in CC.CRED.04.	
7.8.5.7	Provide training for its providers and maintain records of such training;	Full	Evidence of provider training provided	
7.8.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Minimal	QAPIC committee minutes do not show evidence of presentation/discussion/follow-up related to provider complaints. Also not addressed in QAPI Program Evaluation. The plan does produce reports of provider complaints and evidence of reports was provided.	MCO response: The new provider complaint process was implemented in April of 2013. Starting in June of 2013, the Provider Complaint metrics have been reported and tracked in the PIT meeting. The PIT meeting minutes are included in the QAPIC committee minutes and QAPI Program Evaluation.

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**
				IPRO response: No change in determination. QAPIC meeting minutes will be reviewed to ensure metrics are being tracked appropriately, as part of next year's audit.
7.8.5.9	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 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.	Full	Addressed in LA.PRVR.03.	
7.8.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Non-Compliance (Determination changed to "Substantial")	The Network Development and Management Plan provided only states that an evaluation after year one will occur. No evidence of an evaluation was provided. The Q2 Reporting provided states requirements and lays out the steps to be taken if inadequacy noted. LHC should conduct an assessment of the success of the initial plan and determine actions in response.	MCO response: UPLOADED DOCUMENTS TO COMPLIANCE 360 -2012 Q4 Network Review -2012 Q4 Network GeoAccess Maps -2012 Q4 Network Development and Management Plan The Network Team conducts quarterly evaluations of the provider network. The documents above illustrate the annual evaluation for 2012. The development and management plan references the effectiveness of filling network gaps. No Network gaps were identified during the 2012 evaluation. The plan will complete its 2013 network evaluation in January 2014 and implement network interventions if needed. IPRO response: Based on a re-review of the uploaded documents, the review determination changed to "substantial". The plan should document that the evaluation was submitted to the DHH.
7.8.7	CCN Network Development and Management policies shall be subject to approval by DHH,	N/A	DHH Responsibility	

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**
	Medicaid Coordinated Care Section and shall be monitored through operational audits.			
7.9	**Material Change to Provider Network**			
7.9.1	The CCN shall provide written notice to DHH, no later than seven (7) business days. of any network provider contract termination that materially impacts the CCN's provider network, whether terminated by the CCN or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the CCN's ability to meet the performance and network standards as described in the Contract, including but not limited to the following:	Full	Addressed in LA.PRVR.23.	
7.9.1.1	Any change that would cause more than five percent (5%) of members in the GSA to change the location where services are received or rendered.	Full	Addressed in LA.CONT.02.	
7.9.1.2	A decrease in the total of individual PCPs by more than five percent (5%);	Full	Addressed in LA.CONT.02.	
7.9.1.3	A loss of any participating specialist which may impair or deny the members' adequate access to providers;	Full	Addressed in LA.CONT.02.	
7.9.1.4	A loss of a hospital in an area where	Full	Addressed in LA.CONT.02.	

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**
	another CCN hospital of equal service ability is not available as required by access standards specified in this RFP; or			
7.9.1.5	Other adverse changes to the composition of the CCN which impair or deny the members' adequate access to providers.	Full	Addressed in LA.CONT.02.	
7.9.2	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. These changes would include, but would not be limited to, changes in expanded services, payments, or eligibility of a new population.	Full	Addressed in LA.CONT.02.	
7.9.3	When the CCN has advance knowledge that a material change will occur, the CCN must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Full	Addressed in LA.CONT.02.	
7.9.4	The request must include a description of any short-term gaps indentified as a result of the change and the alternatives that will be used to fill them.	Non-Compliance	Not addressed in documents provided.	MCO response: Updated P&P LA.CONT.02 by adding article "5" under provider retention. Language was added to outline the process that LHCC will follow to describe network gaps to DHH before a material change to the network. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.

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**
7.9.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the CCN's provider network requires thirty (30) days advance written notice to affected members For emergency situations, DHH will expedite the approval process.	N/A		
7.9.6	The CCN shall notify the 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 when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)]. The notification shall include:	Full	Addressed in LA.CONT.02.	
7.9.6.1	Information about how the provider network change will affect the delivery of covered services, and	Non-Compliance	Contents of the notification not addressed.	MCO response: Updated P&P LA.CONT.02 by adding items "a" and "b" under item "12" in the Provider Selection: a. Explains process of notifying members linked to a PCP that is no longer in network and getting them linked to a new PCP to prevent disruption of services; and b. Explains process of updating the directory to remove specialists who are no longer in the network to provide them with an accurate list of in network specialists. 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**
				No change in determination. Updated policy will be reviewed as part of next year's audit.
7.9.6.2	The CCN's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	Non-Compliance	Contents of the notification not addressed.	MCO response: Updated P&P LA.CONT.02 by adding item "5" under Provider Retention. Added language that explains the methods that LHCC will employ to ensure continuity of care for members in the event of a material change. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
7.9.7	CCN's 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.	Full	Addressed in provider agreements.	
7.10	**Coordination with Other Service Providers**			
7.10	The CCN shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early Intervention programs; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).	Full	Addressed in LA.CONT.02.	
7.11	**Patient-Centered Medical Home (PCMH)**			

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**
7.11.1	Patient-Centered Medical Home (PCMH) is a system of care led by a team of primary care providers who partner with the patient, the patient's family and the community to coordinate care in all settings, from specialists and hospitals to pharmacies, mental health programs, and home health agencies. The CCN shall promote and facilitate the capacity of primary care practices to function as patient-centered medical homes by using systematic, patient-centered and coordinated care management processes; and to receive National Committee on Quality Assurance (NCQA) Physician Practice Connections®-Patient-Centered Medical Home (PPC®-PCMH) recognition or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home (PCH) accreditation.	Full	Addressed in LA.QI.30 Patient Centered Medical Home and the Medical Home Program Description and Implementation Plan.	
7.11.2	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. The implementation plan shall include, but not be limited to:	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.2.1	Payment methodology for payment to primary care practices for the specific purpose of supporting	Full	Addressed in Medical Home Program Description and Implementation 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**
	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;			
7.11.2.2	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);	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.2.3	Facilitation of specialty provider network access and coordination to support the PCMH; and	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.2.4	Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.3	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		
7.11.3.1	By the end of the first year of operations under the Contract: • Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited.	N/A	Addressed in Medical Home Program Description and Implementation Plan. Per the MCO, approximately 9% of practices have achieved recognition/accreditation. DHH has extended the date for achieving the one year goal to June 2013. Final results pending at time of review.	
7.11.3.2	By the end of the second year of operation under the Contract:	Full	Addressed in Medical Home Program Description and Implementation 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**
	• Total of 30% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited and a • Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited.			
7.11.3.3	By the end of the third year of operation under the Contract: Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited, • Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited, and a • Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.4	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.	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.5	The CCN shall participate in Patient-Centered Primary Care Collaborative activities.	Full	Addressed in Medical Home Program Description and Implementation Plan.	
7.11.6	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.	Full	Addressed in LA.QI.30.	

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**
7.11.7	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 Medical Home Program Description and Implementation Plan.	
7.12	**Subcontract Requirements**			
7.12.1	The CCN shall provide or assure the provision of all core benefits and services. The CCN may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the CCN for services rendered. Provider contracts are required with all providers of services unless otherwise approved by DHH. Any plan to delegate responsibilities of the CCN to a major subcontractor shall be submitted to DHH for approval.	Full	Addressed in LA.CONT.02.	
7.12.2	In order to ensure that members have access to a broad range of health care providers, and to limit the potential for disenrollment due to lack of access to providers or services, the CCN shall not have a	Full	Addressed in LA.CONT.02.	

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**
	contract arrangement with any service provider in which the provider represents or agrees that it will not contract with another CCN or in which the CCN represents or agrees that it will not contract with another provider. The CCN shall not advertise or otherwise hold itself out as having an exclusive relationship with any service provider.			
7.12.3	The CCN shall have written policies and procedures for selection and retention of providers.	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.12.3.1	The CCN shall follow the state's credentialing and re-credentialing policy.	Full	Addressed in LA.CONT.02 Network Selection and Retention and CC.CRED.04 Initial Credentialing Process.	
7.12.3.2	The CCN provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Full	Addressed in LA.CONT.02 Network Selection and Retention and Network Development and Management Plan.	
7.12.4	All laboratory testing sites providing services under this Contract must have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.	Full	Addressed in LA.CONT.02 Network Selection and Retention.	
7.12.5	The CCN shall be responsible to oversee all subcontractors' performance and shall be held accountable for any function and responsibility that it delegates to	Full	LHC subcontracts with the following entities: Cenpatico: specialty therapy and rehabilitation services National Imaging Associates (NIA): radiology services First Transit: transportation (subcontract terminated 5/31/13)	

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**
	any subcontractor, including, but not limited to:		NurseWise: 24 hour nurse line Nurtur Health: disease management US Script: pharmacy services OptiCare: vision services TMS: transportation (eff. 6/1/13) The following documents address subcontractor oversight: CC.COMP.21 Vendor Oversight Program Description CC.COMP.21.01 Invoking Vendor Penalties CC.COMP.21.02 Quality/Service Improvement Plans and Corrective Action Plans for Vendor Noncompliance CC.COMP.21.04 Annual Vendor Audits CC.COMP.21.05 Oversight of Delegated Vendor Evidence in C360 CC.MEDM.QI.18 Oversight of Delegated QM LA.UM.15 Oversight of Delegated UM	
7.12.5.1	All provider subcontracts must fulfill the requirements that are appropriate to the service or activity delegated under the subcontract.	Full	Subcontractor agreements for all entities were found compliant.	
7.12.5.2	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.	N/A		
7.12.5.3	The CCN must evaluate the prospective subcontractor's ability to perform the activities to be delegated.	Full	The only new entity subject to a pre-delegation audit was TMS. The audit was completed in September 2012 and the entity scored 95.8-100% across 5 elements.	
7.12.5.4	The CCN must have a written agreement between the CCN and the subcontractor that specifies the activities and reporting responsibilities delegated to the	Full	Subcontractor agreements were found compliant.	

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**
	subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.			
7.12.5.5	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.	Full	Annual audits were conducted for all entities as indicated. Calls are held with the subcontractors to discuss results and formal responses are provided by the subcontractors. LHC hold quarterly (some times more frequently) Joint Operating Committee calls with each subcontractor. Formal agendas and minutes are maintained. Follow-up actions are noted.	
7.12.5.6	The CCN shall identify deficiencies or areas for improvement, and take corrective action.	Full	Corrective actions are noted in Joint Operating Committee meeting minutes and as a result of annual audits.	
7.12.5.7	The CCN shall specifically deny payments to subcontractors for Provider Preventable Conditions.	Full	Addressed in provider agreements.	
7.12.6	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 LA.CONT.02.	
7.12.7	Notification of amendments or changes to any provider subcontract which materially affects this Contract shall be provided to DHH prior to the execution of the	Non-Compliance	Not addressed in documents provided.	MCO response: Updated LA.CONT.02 to include language regarding the notification to DHH Prior to execution of a provider subcontract amendment.

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**
	amendment.			IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
7.12.8	The CCN shall not execute provider 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 CC.CRED.04 Initial Credentialing Process and CC.CRED.05 Initial Sanction Information.	
7.12.9	The CCN shall provide written notification to DHH of its intent to terminate any provider subcontract that may materially impact the CCN's provider network and/or operations, as soon as possible, but no later than seven (7) calendar days prior to the effective date of termination. In the event of termination of a provider subcontract for cause, the CCN shall provide immediate written notice to the provider.	Substantial	Addressed in LA.PRVR.23. However, language should be more specific detailing the MCO's responsibilities. The policy states: "all contractual obligations with State agency must be followed".	MCO response: Updated LA.PRVR.23 language regarding network termination process. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
7.12.10	If termination is related to network access, the CCN shall include in the notification to DHH their plans to	Full	Addressed in LA.CONT.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**
	notify CCN members of such change and strategy to ensure timely access to CCN members through out-of-network providers. If termination is related to the CCN's operations, the notification shall include the CCN's plan for how it will ensure that there will be no stoppage or interruption of services to member or providers.			
7.12.11	The CCN shall make a good faith effort to give written notice of termination of a subcontract provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider.	Full	Addressed in LA.MBRS.27.	
7.13	**Provider-Member Communication Anti-Gag Clause**			
7.13.1	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 the benefits for such care or treatment are provided under the Contract, for the following:	Full	Addressed in provider agreements.	
7.13.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Full	Addressed in provider agreements.	

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**
7.13.1.2	Any information the member needs in order to decide among relevant treatment options;	Full	Addressed in provider agreements.	
7.13.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Full	Addressed in provider agreements.	
7.13.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Full	Addressed in provider agreements.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
8.1	**General Requirements**			
8.1.1	The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. The CCN shall submit UM policies and procedures to DHH for written approval within thirty (30) days from the date the Contract is signed, annually thereafter, and prior to any revisions.	Full	Addressed in UM.01 UM Program description, which describes the plan's UM and Service Authorization process.	
8.1.2	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 a contracting health care professionals; are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; are consider the needs of the members; are reviewed annually and updated periodically as appropriate.	Full	Addressed in UM 02 Clinical Decision Criteria and Application. NCQA standards and InterQual standards are followed.	
8.1.3	The policies and procedures shall include, but not be limited to:	N/A		
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	Full	Methodology specified in UM 02 Clinical Decision Criteria and Application. All UM case files reviewed contained evidence that decisions were made using clinical evidence.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
8.1.3.2	The data sources and clinical review criteria used in decision making;	Full	Addressed in UM 02 Clinical Decision Criteria and Application.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Full	Addressed in UM 02 Clinical Decision Criteria and Application. Clinical reviews were documented in the case files reviewed.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Full	Addressed in UM 05 Timeliness of UM Decisions and Notifications.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Full	Addressed in UM 02 Clinical Decision Criteria and Application.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services; and	Full	Addressed in UM 02 Clinical Decision Criteria and Application.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information.	Full	Confidentiality is noted in UM 01, The UM Program Description.	
8.1.4	The CCN shall coordinate the development of clinical practice guidelines with other DHH CCN's to avoid providers receiving conflicting practice guidelines from different CCN's.	Full	Addressed in UM 02 Clinical Decision Criteria and Application.	
8.1.5	The CCN shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Full	Addressed in UM 02 Clinical Decision Criteria and Application.	
8.1.6	The CCN shall take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers are	Substantial	Substantially addressed in QI.20 EPSTD Guidelines and QI 23 Physician Incentive Plan. Providers are monitored and a P4P program is in effect. Policies do not specify that 90% or more of providers are consistently in compliance. Several areas are monitored, including but not limited to: performance measures, satisfaction,	MCO response: To be fully compliant, the plan will add practice guidelines to the monitoring activity within the policy and assess providers at the 90% performance standard. IPRO response:

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	consistently in compliance, based on CCN measurement findings. The CCN should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.		complaints, and UR. To be fully compliant, the plan should explicitly include practice guidelines in its monitoring activity and assess providers at the 90% performance standard.	No change in determination. Updated policy and documentation that the plan instituted a 90% compliance standard will be reviewed as part of next year's audit.
8.1.7	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		
8.1.7.1	The vendor must be identified if the criteria was purchased;	Full	Addressed in UM 02 Clinical Decision Criteria and Application. InterQual is used.	
8.1.7.2	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 UM 02 Clinical Decision Criteria and Application.	
8.1.7.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Full	Addressed in UM 02.01 Medical Necessity Decision Process, which notes NCD, LCD, and/or InterQual criteria.	
8.1.7.4	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 UM 04 Appropriate UM professionals. The plan's Medical Director is primary in the review.	
8.1.8	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential	Full	Addressed in UM 02.13 and in the Provider Manual.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	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.			
8.1.9	The CCN shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the CCN determines the need for additional information not initially requested.	Full	Addressed in UM 06 Clinical Information and documentation, which lists the information required for UM decision-making.	
8.1.10	The CCN shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the CCN may deny authorization of the requested service(s).	Full	Addressed in UM 05 Timeliness of UM Decisions and Notifications.	
8.1.11	The CCN shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.	Full	Addressed in UM 01 UM Program Description and UM 04 Appropriate UM Professionals.	
8.1.12	The CCN shall use DHH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical	Full	Addressed in UM 02 Medical Necessity Review.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	necessity determinations. The CCN shall specify what constitutes "medically necessary services".			
8.1.13	The CCN shall address the extent to which it 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 attain, maintain, or regain functional capacity.	Full	Addressed in QI 20 EPSTDT policy, which describes process for covering and monitoring EPSTD services.	
8.1.14	The CCN must identify the qualification of staff who will determine medical necessity.	Full	Addressed in UM 04 Appropriate UM Professionals.	
8.1.15	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Full	Addressed in UM 04 Appropriate UM Professionals.	
8.1.16	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.	Full	Addressed in UM 04 Appropriate UM Professionals. Case file review revealed that clinical staff were responsible for making UM decisions.	
8.1.17	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,	Substantial (Based upon a re-review of UM.04, requirement was found to be compliant.	Addressed in UM 04 Appropriate UM Professionals. To be fully compliant, the policy should explicitly note that the individual should have "no history of disciplinary or sanctions, including loss of staff privileges". The policy does state that the MD staff must have "an active, unencumbered Louisiana license."	MCO response: LA.UM.04 Appropriate UM Professionals Statement is located on page 1 under "Policy"; however, we have now made it italicized and bold font for easy recognition.

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	Determination changed to "Full")		IPRO response: LA.UM.04 was re-reviewed and found to be in compliance. Based on the re-review, determination has been changed to "Full."
8.1.18	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.	Full	Addressed in UM 04 Appropriate UM Professionals, which states that only a Medical Director can make an adverse determination.	
8.1.19	The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.1.19.1	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.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.1.19.2	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.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.1.19.3	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	Full	Addressed in UM 01.01 Covered Benefits and Services.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	reasonably be expected to achieve their purpose.			
8.1.20	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 UM 01 Program Description (p5).	
8.1.21	The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit.	Full	Addressed in UM 01 Program Description (p20).	
8.1.22	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:	N/A		
8.1.22.1	Identification of the enrollee;	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making.	
8.1.22.2	The name of the enrollee's physician;	Substantial	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making. To be fully compliant, this element (i.e., provider name) should be explicitly added to the list.	MCO response: Health plan added required language to list in both policies, UM.06 and UM 06.02. IPRO response: No change in determination. Updated policies will be reviewed as part of next year's audit.
8.1.22.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	made after admission;		making.	
8.1.22.4	The plan of care;	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making.	
8.1.22.5	Initial and subsequent continued stay review dates;	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making.	
8.1.22.6	Date of operating room reservation, if applicable;	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making.	
8.1.22.7	Justification of emergency admission, if applicable.	Full	Addressed in UM.06 Clinical Information and Documentation and UM 06.02 Documentation in TruCare Notes, which lists the criteria for UM decision making.	
8.2	**Utilization Management Committee**			
8.2.1	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 01 Program Description (p 4 and 5).	
8.2.2	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 than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting. UM Committee responsibilities include:	Full	Addressed in UM 01 Program Description (p 4 and 5). UM Committee Meeting Quarterly meeting minutes are prepared and were submitted for review.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
8.2.2.1	Monitoring providers' requests for rendering healthcare services to its members;	Substantial	Provider evaluation and utilization policy is addressed in CC.QI.22 Provider Profiling Program but monitoring requests for rendering healthcare services is not explicitly stated.	MCO response: Health Plan will add to policy CC.QI.22 "Monitoring of providers' requests for rendering healthcare services." IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
8.2.2.2	Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	Full	Addressed in CC.QI.22 Provider Profiling Program and provider profile reports.	
8.2.2.3	Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Substantial	Utilization review is addressed in CC.QI.22 Provider Profiling Program and profile reports but how effectiveness results in changes to the process is not indicated.	MCO response: Health Plan will add to policy CC.QI.22 "Utilization review process will be evaluated for effectiveness and processes will be revised or changed as needed according to the results of the evaluation." IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
8.2.2.4	Approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;	Substantial (Based upon a re-review of UM.02.05, requirement was found to be compliant. Determination changed to "Full")	UM 02.05 details the criteria for monitoring Medical Management Staff. To be fully compliant, the policy should either explicitly describe the industry standards that are being assessed or refer to another existing policy in which the standards are defined.	MCO response: The industry standards are located in LA.UM.02.05 on page 1 in "Work Process". The health plan has now made it italicized and bold font for easy recognition. IPRO response: LA.UM.02.05 was re-reviewed and found to be in compliance. Based on the re-review, determination has been changed to "Full."
8.2.2.5	Monitoring consistent application of "medical necessity" criteria;	Full	UM 02.05 describes the policy for monitoring interrater reliability of medical management staff.	
8.2.2.6	Application of clinical practice guidelines;	Full	Policy UM 02 describes how clinical decisions are made and documented using all relevant clinical information	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
			and are based on written, nationally recognized clinical decision support criteria.	
8.2.2.7	Monitoring over- and under-utilization;	Full	Addressed in UM 01, Program Description (p4).	
8.2.2.8	Review of outliers, and	Full	Addressed in UM 01, Program Description (p4).	
8.2.2.9	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	Addressed in QI.13 Medical Record Review policy.	
8.2.2.9.1	Medical Record Review Strategy	N/A		
8.2.2.9.1.1	The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed and annually thereafter. 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.).	Full	Addressed in QI.13 Medical Record Review policy.	
8.2.2.9.1.2	The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all	Full	Medical Record Review Policy is described in the Provider Manual.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	providers.			
8.2.3	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 QI.13 Medical Record Review policy.	
8.2.4	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 in specific instances.	Full	Addressed in QI.13 Medical Record Review policy.	
8.2.5	The CCN shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Full	Addressed in QI.13 Medical Record Review policy.	
8.3	**Utilization Management Reports**			
8.3.0	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	Addressed in QI.13 Medical Record Review policy. UM Pre-certification reports sent to DHH were submitted for review.	
8.4	**Service Authorization**			
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post	Full	Addressed in UM 01 Program Description and UM 05, Timeliness of UM Decisions and Notification	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	authorization.			
8.4.2	The CCN UM Program policies and procedures shall include service authorization policies and procedures for initial and continuing authorization of services that include, but are not limited to, the following:	N/A		
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	Full	Addressed in UM 01 Program Description and UM 05 Timeliness of UM Decisions and Notification.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Substantial	Addressed in UM 01 Program Description and UM 05 Timeliness of UM Decisions and Notification. To be fully compliant, policy should explicitly state the "consistent application of review criteria… in consultation with the requesting provider."	MCO response: Required language was added to Inter-rater Reliability section of LA.UM.01 Program description. The health plan also added this language to LA.UM.02.05, Interrater Reliability. IPRO response: No change in determination. Updated policies will be reviewed as part of next year's audit.
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	Full	Addressed in UM 01 Program Description, UM 04 Appropriate UM Professionals and UM 05 Timeliness of UM Decisions and Notification.	
8.4.2.4	Provide a mechanism in which a	Minimal	Addressed in UM 05 Timeliness of UM Decisions and	MCO response:

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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 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;		Notification. In the 20 Appeals that were reviewed, there was no mention of the right for members to see case files or medical records.	The Plan will add to the grievance and appeals procedure the verbiage explaining to the members that they have the right to see case files or medical records utilized in their appeals process. The same verbiage will be added to the Member Appeals Acknowledgement letter. IPRO response: No change in determination. Updated procedure and acknowledgement letter will be reviewed as part of next year's audit.
8.4.2.5	The CCN's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	Substantial	Service Authorization is addressed in UM 01 Program Description and UM 05 Timeliness of UM Decisions and Notification. Policy does not state that the authorization number and effective dates are captured in the Service Authorization system.	MCO response: Language added to LA.UM.06.04 TruCare Standards for Documentation under purpose. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
8.4.2.6	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.	Minimal	Partially addressed in UM 01 Program Description and UM 05 Timeliness of UM Decisions and Notification. Policy should state that timeframes, requests and decisions will be captured in the Service Authorization system. In six of the UM denials that were reviewed, the system (via a screen shot) described the type of review differently than what was specified on the hardcopy file (e.g., system identified one as "Retro" and the case file described it as "concurrent").	MCO response: This is currently documented in the 'purpose' section. These cases were early on, education was provided to staff. Weekly validation and audits indicate documentation process has been corrected. IPRO response: No change in determination. Next year's audit will compare the information in the system with the hardcopy files to ensure that the discrepancy between the two processes has been corrected.
8.5	**Timing of Service Authorization Decisions**			
8.5.1.1	Standard Service Authorization	N/A		
8.5.1.1.1	The CCN shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification (p1).	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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 medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination. Standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested.			
8.5.1.1.2	An extension may be granted for an additional fourteen (14) calendar days if the member or the provider or authorized representative requests an extension or if the CCN justifies to DHH a need for additional information and the extension is in the member's best interest. In no instance shall any determination of standard service authorization be made later than (28) calendar days from receipt of the request.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification (p2).	
8.5.1.1.3	The CCN shall make concurrent review determinations within one (1) business day of obtaining the appropriate medical information that may be required.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification. All concurrent reviews in the case files were timely.	
8.5.1.2	Expedited Service Authorization	N/A		
8.5.1.2.1	In the event a provider indicates, or the CCN determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN shall make an expedited	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	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.			
8.5.1.3	Post Authorization The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the CCN justifies to DHH a need for additional information and how the extension is in the member's best interest.	N/A	Extension of 72 hours up to 14 days is not addressed in the policy but a communication from DHH after the onsite audit was conducted indicated that this timeframe was misplaced in the contract and that the contract language will be modified.	
8.5.1.3.1	The CCN shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification. All retrospective file reviews were timely.	
8.5.1.3.2	The CCN shall not subsequently retracts its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	Non-Compliance (Based on re-review conducted subsequent to the issuance of the preliminary compliance report, determination is "Full")	Policy regarding retraction of authorization is not stated in policy.	MCO response: Located in LA.UM.05 Timeliness of UM Decisions and notifications, page 1, "Policy". Health Plan made language bold and italicized for emphasis. The policy was turned in the next morning for review after audit. IPRO response: LA.UM.05 was re-reviewed and found to be in compliance. Based on the re-review, determination has been changed to "Full."
8.5.1.4	Timing of Notice	N/A		
8.5.1.4.1	Notice of Action	N/A		

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
8.5.1.4.1.1	Approval [Notice of Action]	N/A		
8.5.1.4.1.1.1	Approval - For service authorization approval for a non-emergency 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.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification.	
8.5.1.4.1.1.2	Approval - 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.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification.	
8.5.1.4.2	Adverse [Notice of Action]	N/A		
8.5.1.4.2.1	Adverse - 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 adverse action.	Full	Addressed in UM 07 Adverse Determination Decisions. In three of the 20 UM Denial cases that were reviewed, there was no letter informing the member of the resolution, in all cases the appeal was overturned and the member received the service. Onsite, it was clarified that DHH does not require plans to contact members in the event that the decision is overturned. Despite this, it is recommended that the plan contact the member regardless of the determination.	
8.5.1.4.2.2	Adverse - The CCN shall notify the requesting provider of a decision to	Full	Addressed in UM 07 Adverse Determination Decisions.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.			
8.5.1.5	Informal Reconsideration	N/A		
8.5.1.5.1	As part of the CCN appeal procedures, the CCN should include an Informal Reconsideration process that allows the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification.	
8.5.1.5.1.1	In a case involving an initial determination or a concurrent review determination, the CCN should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination.	Minimal (Determination changed to "Substantial")	Policy addressed in UM 05 Timeliness of UM Decisions and Notification. For the five concurrent reviews that were audited, there was no opportunity offered to the member for an Informal Reconsideration.	MCO response: This is addressed in Louisiana Department of Health and Hospitals Health Plan Advisory 12-9. Concurrent reviews and post-service reviews are considered a provider appeal and not a member appeal due to the fact that the member is held harmless; therefore, no designated representative form is required. This information was given to reviewers during the audit. IPRO response: Review determination changed to "substantial". Even though the member is held harmless, there should be some contact between the plan and the member to document that the issue has been resolved and provide the member with an opportunity for additional follow-up and possible Informal Reconsideration.
8.5.1.5.1.1.2	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the CCN's physician authorized to make adverse determinations or a	Substantial	Plan does conduct Informal Reconsiderations but policy should clarify the circumstances which a member can request one. The one working day timeframe is not noted. The file review indicated that many Informal Reconsiderations are not accomplished within one	MCO response: The Plan will revise the policy addressing the informal reconsideration process to include the following verbiage: The informal reconsideration should occur within one (1) working day of the receipt of the request and should

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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 peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.		working day. However, the reason for the delay was usually due to the rendering provider not being available or to a delay in sending the plan the necessary clinical information to make a determination. It might be helpful to include a field in the system to record the date that all information was received. In that way, the timeframe between the date when information is received and the plan's determination can be tracked.	be conducted between the provider rendering the service and the CCN's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
8.5.1.5.2	The Informal Reconsideration will in no way extend the 30 day required timeframe for a Notice of Appeal Resolution.	Full	Addressed in UM 05 Timeliness of UM Decisions and Notification.	
8.5.1.6	Exceptions to Requirements	N/A		
8.5.1.6.1	The CCN shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	Full	Addressed in UM 12 Emergency and Post Stabilization Services.	
8.5.1.6.2	The CCN shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.5.1.6.3	The CCN shall not require service authorization or referral for EPSDT screening services.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.5.1.6.4	The CCN shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the CCN, regardless of whether such services are provided by an in-network or	Full	Addressed in UM 16 Continuity and Coordination of Services.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days.			
8.5.1.6.5	During transition, the CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.	Full	Addressed in UM 16 Continuity and Coordination of Services.	
8.5.1.6.6	The CCN shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal care.	Full	Addressed in UM 01.02 Women's Health and Family Planning Services and UM 16.01 Referrals to Specialty Health Care Services where policy states members can self refer for women's health services.	
8.5.1.6.7	The CCN shall not require a PCP referral for in-network eye care and vision services.	Full	Addressed in UM 01.01 Covered Benefits and Services.	
8.5.1.6.8	The CCN may request to be notified by the provider, but shall not deny claims 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 UM 01.01 Covered Benefits and Services.	
8.6	**Medical History Information**			
8.6.1	The CCN is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed	Full	Addressed in UM.06, Clinical Information and Documentation.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	and/or as requested by DHH, for purposes of making medical necessity determinations.			
8.6.2	The CCN shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	Full	Provider contracts stipulate that providers must cooperate with any internal or external quality of care assessment.	
8.6.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	Full	Provider contracts stipulate that the plan can impose financial penalties for failure to comply Not paying providers who do not cooperate.	
8.6.4	Should a provider fail or refuse to respond to the CCN's request for medical record information, at the CCN's discretion or directive by DHH, the CCN shall, at a minimum, impose financial penalties against the provider as appropriate.	Full	Provider contracts stipulate that financial penalties will be imposed if a provider fails to respond to the plan's request for medical record information.	
8.7	**PCP Utilization and Quality Profiling**			
8.7.1	The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues.	Full	Provider profile reports are prepared and were submitted for review.	
8.7.2	The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Full	Addressed in provider contracts and performance assessment is addressed in the Provider Manual.	
8.7.3	The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall	Full	Quarterly profile report was submitted for review.	

Utilization Management (UM)				
State Contract Requirements [Federal Regulation: 438.210, 438.236, 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**
	include, but are not limited to, the following:			
8.7.3.1	Utilization of out-of-network providers – The CCN shall maintain a procedure to identify and evaluate member out-of-network provider referral utilization by its PCP panel;	Full	Counts of non-participating providers are presented in the plan's Provider Data Management Dashboard. A comparison can be made between Participating and non-participating providers.	
8.7.3.2	Specialist referrals – The CCN shall maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel;	Full	Specialist referrals are incorporated into the provider profile reports.	
8.7.3.3	Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel;	Full	ED utilization is incorporated into the provider profile reports.	
8.7.3.4	Hospital admits, , lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and	Full	Hospital admissions, labs, pharmacy and radiology are incorporated into the provider profile/utilization reports.	
8.7.3.5	Individual PCP clinical quality performance measures as indicated in Appendix J.	Full	HEDIS measures are calculated, trended and reported.	
8.8	**PCP Utilization & Quality Profile Reporting Requirements**			
8.8.0	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.	Full	Quarterly reports are prepared with the annual summary incorporated into the 1/30 report.	

Provider Relations				
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**
10.4	**Provider Handbook**			
10.4.1	The CCN shall develop and issue a provider handbook within thirty (30) days of the date the CCN signs the Contract with DHH. The CCN may choose not to distribute the provider handbook via surface mail, provided it submits a written notification to all 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 covered 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	LA.PRVR.02 Provider Manual addresses compliance of the Provider Manual (Provider Handbook) with State contract requirements. The Manual is distributed to providers during orientation visits conducted by the Provider Relations staff. Provider Manual is available on the LHC website and is available in hard copy upon request.	
10.4.1.1	Description of the CCN;	Full	Addressed in Provider Manual.	
10.4.1.2	Description and requirements of Patient-Centered Medical Home recognition;	Full	Per Provider Manual, LHC will support providers seeking NCQA or JCAHO recognition. Providers are directed to the LHC website for additional information.	
10.4.1.3	Core benefits and services the CCN must provide;	Full	Addressed in Provider Manual.	
10.4.1.4	Emergency service responsibilities;	Full	Addressed in Provider Manual.	
10.4.1.5	Policies and procedures that cover	Full	Addressed in Provider Manual. Per Manual, the term	

Provider Relations				
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 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;		grievance is used throughout the document for both member grievances and provider complaints as resolution processes are the same.	
10.4.1.6	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;	Full	Addressed in Provider Manual.	
10.4.1.7	Medical necessity standards as defined by DHH and practice guidelines;	Full	Addressed in Provider Manual.	
10.4.1.8	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Full	Addressed in Provider Manual.	
10.4.1.9	PCP responsibilities;	Full	Addressed in Provider Manual.	
10.4.1.10	Other provider responsibilities under the subcontract with the CCN;	Full	Addressed in Provider Manual.	
10.4.1.11	Prior authorization and referral procedures;	Full	Addressed in Provider Manual.	
10.4.1.12	Medical records standards;	Full	Addressed in Provider Manual.	
10.4.1.13	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and	Full	Addressed in Provider Manual.	

Provider Relations				
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**
	samples of clean and complete claims;			
10.4.1.14	CCN prompt pay requirements;	Full	Addressed in Provider Manual.	
10.4.1.15	Notice that provider complaints regarding claims payment shall be sent to the CCN;	Full	Addressed in Provider Manual.	
10.4.1.16	The CCN's chronic care management program;	Full	Addressed in Provider Manual.	
10.4.1.17	Quality performance requirements; and	Full	Addressed in Provider Manual.	
10.4.1.18	Provider rights and responsibilities.	Full	Addressed in Provider Manual.	
10.4.2	The CCN shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Full	Sample bulletins provided.	
10.6	**Provider Complaint System**			
10.6.1	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 LA.PRVR.03 Provider Complaints.	
10.6.1.1	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	Addressed in PRVR.03.	
10.6.1.2	Identify a staff person specifically designated to receive and process provider complaints;	Full	Addressed in PRVR.03.	
10.6.1.3	Thoroughly investigate each	Full	Addressed in PRVR.03. Provider complaints are	

Provider Relations				
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**
	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		acknowledged within 3 business days of receipt in writing or in same manner as complaint was received. Goal is to resolve within 30 business days and provide written notice. If not resolved within 30 days, the reason will be documented. All complaints are to be resolved within 90 business days.	
10.6.1.4	Ensure that CCN executives with the authority to require corrective action are involved in the provider complaint process as necessary.	Full	Addressed in PRVR.03.	
10.6.2	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 procedures to DHH for review and approval within thirty (30) Calendar Days of the date the Contract with DHH is signed. The policies and procedures shall include, at a minimum:	Full	Addressed in PRVR.03.	
10.6.2.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file complaint with the CCN and the resolution time;	Substantial	Timeframe is addressed in PRVR.03 and Provider Manual. The Manual does not specify a timeframe however PRVR.03 notes 30 days. These documents should be consistent.	MCO response: The Provider Manual will be revised to specify a timeframe for providers to file a complaint with LHCC consistent with the timeframe provided in LA.PRVR.03. IPRO response: No change in determination. Updated Provider Manual will be reviewed as part of next year's audit.
10.6.2.2	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	Substantial	Provider Manual partially addresses this requirement. The Manual does not address circumstances for filing a complaint directly to DHH/MMIS.	MCO response: Applicable pages of the online Provider Manual have been updated. IPRO response: No change in determination. Updated Provider Manual

Provider Relations				
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**
	provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the CCN;			will be reviewed as part of next year's audit.
10.6.2.3	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;	Substantial	Per PRVR.03, provider relations staff receives training on distinguishing between member grievances (where the provider is acting on the member's behalf) vs. a provider complaint. The Internal PR/PCC Training Agenda for June 2013 included a topic of Provider Complaint Process. It is not clear that this topic addressed this requirement. The Provider Complaint System Training document dated 4/25/13 notes that upon investigation, the definition of a provider complaint is inconsistent across departments. A standardized definition was created and is expected to result in a higher number of logged complaints. Training in the new definition should be enhanced with training on distinguishing between the situations noted in this requirement.	MCO response: Provider Relations did not typically take minutes for staff meeting items discussed. If an item is on the Agenda, the item is fully discussed. However, after the audit, it became clear that is what is expected, so we have begun taking minutes and requiring sign in sheets for such meetings. This item will be on the agenda and discussed at the next regularly scheduled meeting to be held on November 21, 2013. IPRO response: No change in determination. Training agendas will be reviewed as part of next year's audit. It is expected that training include education regarding the standardized definition and how to distinguish between a provider complaint and an enrollee grievance.
10.6.2.4	A process to allow providers to consolidate complaints of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint;	Full	Addressed in LA.PRVR.03. Per LHC, providers are advised of this during phone calls with provider reps. It is suggested that LHC update the Provider Manual to inform providers of this process.	
10.6.2.5	A process for thoroughly investigating each complaint using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation.	Full	Addressed in LA.PRVR.03.	
10.6.2.6	A description of the methods used to ensure that CCN executive staff with the authority to require	Full	Addressed in LA.PRVR.03.	

Provider Relations				
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**
	corrective action are involved in the complaint process, as necessary;			
10.6.2.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Full	LA.PRVR.03 includes this requirement upon provider request.	
10.6.2.8	Identification of specific individuals who have authority to administer the provider complaint process;	Full	Addressed in LA.PRVR.03.	
10.6.2.9	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	Substantial	Provider complaints are stored electronically in the CRM system. **Provider Complaint File Review** A total of 20 provider complaint files were reviewed. Of the 20 files, 16 were fully compliant. Two files were resolved untimely and one file lacked sufficient documentation of the investigation. In another file, the final resolution was not clear and the resolution language included in the resolution letter was confusing. **LHC Provider Satisfaction Survey Report** (undated) Response rate = 5.9% (mail/internet option) Response rate = 30.2% (f/u phone call) The following results are pertinent to the provider complaint process and the nature of the complaints as they are mostly related to claims issues. 35.4% satisfied with resolution of claims problems or disputes 43.4% satisfied with helpfulness of provider services staff in resolving claims issues 41.9% satisfied with timeliness to answer questions and/or resolve problems	MCO response: DISPUTE - Provider complaints are stored electronically in the CRM system. • The provider complaints are not only stored electronically in CRM, they are also logged and tracked on Sharepoint. • The provider complaints are trended on a weekly basis on a Provider Complaint Dashboard and reported to management. Provider Complaint File Review: • The 20 samples reviewed were from the beginning of the new complaint process in April. • Since the implementation of the new process, LHCC has developed standardized response templates to ensure resolutions are accurate and complete. • The resolution letters go through a review process prior to them being sent to a provider. IPRO response: No change in determination. The "substantial" determination was based on file review results. The CRM system that houses provider complaints met the standard for the system requirement. File review will be conducted as part of next year's audit and will be based on LHC's new complaint process.

Provider Relations				
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**
10.6.2.10	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 LA.PRVR.03. Provider Complaint and Appeal Summary reports for the period of 8/12 through 6/13 were provided. Reports showed total number of complaints received monthly with a high of 439 complaints received in 5/13 and a low of 4 complaints in 12/12. From the period of 8/12 through 3/13, the number of complaints filed monthly was less than 60 per month. April, May and June 2013 showed a significant increase in the number of complaints received; 391, 439 and 267, respectively. The majority of complaints were claims-related. Per LHC, the increased volume of reported complaints is due to the re-definition of a complaint.	
10.6.2.11	Allowing providers that have exhausted the CCNs internal complaint process related to a denied or underpaid claims or a group of claims bundled, the option to request binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the CCN and the provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being	Full	Addressed in the provider agreement.	

Provider Relations				
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**
	selected, unless the CCN and the provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.			
10.6.3	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 Manual.	
10.6.3.1	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 the in-network provider can request a hard copy from the CCN at no charge to the provider.	Full	Addressed in the Provider Manual for in-network providers. Out-of-network providers are informed via the Remittance Advice & Explanation of Payment that information on claim submission, resubmission, request for reconsideration and the claim dispute process is available on the LHC website.	
10.6.3.2	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 the Provider Manual.	
10.6.3.3	Within fifteen (15) business days of	Full	Addressed in the Provider Manual.	

Provider Relations				
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 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.			

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**
11.11	**PCP Auto-Assignments**			
11.11.1	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:	N/A		
11.11.1.1	Does not make a PCP selection after a voluntary selection of a CCN; or	Full	LA.ELIG.04 Primary Care Provider (PCP) Auto-Assignment shows compliance with this standard.	
11.11.1.2	Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or	Full	LA.ELIG.04 Primary Care Provider (PCP) Auto-Assignment shows compliance with this standard.	
11.11.1.3	Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).	Full	LA.ELIG.04 Primary Care Provider (PCP) Auto-Assignment shows compliance with this standard.	
11.11.2	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 auto-assigned 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, auto-assignment shall be made to a provider with who a family member has a historical provider relationship.	Full	LA.ELIG.04 Primary Care Provider (PCP) Auto-Assignment shows compliance with this standard.	
11.11.3	If there is no member or immediate family historical usage, members shall be auto-assigned to a PCP using an algorithm developed by the proposer, based on the age and	Full	LA.ELIG.04 Primary Care Provider (PCP) Auto-Assignment 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**
	sex of the member and geographic proximity.			
11.11.4	The final CCN and PCP automatic assignment methodology must be provided thirty (30) days from the date the CCN signs the contract with DHH. Approval must be obtained from the Department prior to implementation. This methodology must be made available via the CCN's website, Provider Handbook, and Member Handbook.	Substantial	Auto assignment methodology is included in the Member Handbook and Provider Manual. The auto assignment methodology is not specified on LHC's website.	
11.11.5	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	LA.ELIG.03 Primary Care Provider (PCP) Selection and Change shows compliance with this standard.	
11.11.6	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	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.11.7	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 months (12) months beginning from the original date the member was assigned to the CCN.	Full	Addressed in the Member Handbook.	
11.11.8	If a member requests to change his or her PCP with cause, at any time	Full	Addressed in the Member Handbook.	

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**
	during the enrollment period, the CCN must agree to grant the request.			
11.11.9	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 termination of PCP notice to members and provide information on options for selecting a new PCP.	Full	LA.ELIG.03, LA.MBRS.27 show compliance with this standard.	
11.11.11	The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.	Substantial	CC.PRVR.23 Provider Termination Policy shows compliance to notify the Enrollment Broker but the P&P does not state it shall notify the Enrollment Broker by close of business the next business day.	MCO response: Updated LA.PRVR.23 to include "next business day" language. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.
11.12	**Disenrollment**			
11.12	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	Full	LA.ELIG.02 Disenrollment and attachment Request for Member 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**
	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 to the CCN member for notification of disenrollment.			
11.12.1	Member Initiated Disenrollment	N/A		
11.12.1.1	A member may request disenrollment from a CCN as follows: 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; the contract between the CCN and DHH is terminated; poor quality of care; lack of access to CCN core benefits and services covered under the contract; documented lack of access	Full	LA.ELIG.02 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**
	within the CCN to providers experienced in dealing with the member's healthcare needs; and any other reason deemed to be valid by DHH and/or its agent.			
11.12.1.2	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; and upon automatic re-enrollment, if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. If DHH imposes intermediate sanction provisions.	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.1.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.1.4	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	Addressed in the Member Handbook.	
11.12.2	CCN Initiated Disenrollment	N/A		
11.12.2.1	The CCN shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished	Full	LA.ELIG.02 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**
	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 CCN members, 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.			
11.12.2.2	The CCN shall not request disenrollment for reasons other than those stated in this RFP. DHH will ensure that CCN is not requesting disenrollment for other reasons by reviewing 1) the mandatory CCN Disenrollment Request Forms submitted to the Enrollment Broker and 2) Quarterly Disenrollment Reports submitted by the CCN to DHH.	Full	LA.ELIG.02 Disenrollment indicates that the plan follows disenrollment practices.	
11.12.2.3	The following are allowable reasons for which the CCN may request involuntary disenrollment of a member: the member misuses or loans the member's CCN-issued ID card to another person to obtain services. In such case the CCN shall report the event to the Medicaid Program Integrity Section; the member's behavior is disruptive, unruly, abusive or uncooperative to	Full	LA.ELIG.02 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**
	the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members.			
11.12.2.4	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	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.2.5	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.	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.2.6	The CCN shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the CCN Initiated Request for Member Disenrollment form.	Full	LA.ELIG.02 Disenrollment P&P plus attached CCN Request for Member Disenrollment form show compliance with this standard.	
11.12.2.7	The CCN shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier	Full	LA.ELIG.02 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**
	than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The CCN shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.			
11.12.2.8	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the CCN.	Substantial	LA.ELIG.02 Disenrollment P&P plus attached CCN Request for Member Disenrollment form does not specify that the decisions are final and not subject to the dispute resolution process by the plan.	MCO response: Policy LA.ELIG.02 will be updated to specify that the decision made by DHH is final and not subject to dispute. IPRO response: No change in determination. Updated Policy will be reviewed as part of next year's audit.
11.12.2.9	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 disenroll the member from the CCN, the member has a right to file an appeal directly through the State Fair Hearing process.	N/A		
11.12.2.10	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	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3	DHH Initiated Disenrollment: DHH will notify the CCN of the member's disenrollment due to the following reasons:	N/A		
11.12.3.1	Loss of Medicaid eligibility or loss of	Full	LA.ELIG.02 Disenrollment shows compliance with this	

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**
	CCN enrollment eligibility;		standard.	
11.12.3.2	Death of a member;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.3	Member's intentional submission of fraudulent information;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.4	Member becomes an inmate in a public institution;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.5	Member moves out-of-state;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.6	Member becomes Medicare eligible;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.7	Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.8	Member becomes a participant in a home and community-based services waiver;	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.9	Member elects to receive hospice services; and	Full	LA.ELIG.02 Disenrollment shows compliance with this standard.	
11.12.3.10	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	LA.ELIG.02 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**
12.11	**Member Education – Required Materials and Services**			
12.11.0	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	LA.MBRS.01 New Member Orientation and Communication and LA.MBRS.25 P&P indicate compliance with this standard.	
12.11.1.	**New Member Orientation**			
12.11.1.1	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	LA.MBRS.01 New Member Orientation and Communication shows compliance with this standard.	
12.11.1.2	The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed	Full	LA.MBRS.01 New Member Orientation and Communication shows compliance with this standard.	
12.11.1.3	The CCN may propose, for approval by DHH, alternative methods for orienting new members and must	Full	LA.MBRS.01 Initial Member Education meets this standard by stating DHH will provide written approval of changes to the content of the welcome packets prior	

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**
	be prepared to demonstrate their efficacy.		to distribution.	
12.11.1.4	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 PCP names (and include 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	CC.MBRS.04 P&P Distribution of New Member Materials and LA.MBRS.01 show compliance with this standard.	
12.11.1.5	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.	N/A		
12.11.1.6	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	LA.ELIG.04 Auto Assignment Methodology shows compliance with this standard.	
12.11.2	**Communication with New Enrollees**			
12.11.2.1.1	The CCN shall send a welcome	Full	LA.MBRS.01 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**
	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 phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to provide welcome packets.			
12.11.2.1.2	The CCN must mail a welcome packet to each new member. When the name of the responsible party for the new member is associated with two (2) or more new members, the CCN is only required to send one welcome packet.	Substantial	LA.MBRS.01 shows compliance with this standard. It is recommended that policy state that only one welcome packet is required to be mailed to a household.	MCO response: Policy LA.MBRS.01 will be updated to state that only one welcome packet is required to be mailed per household. This is the current process at the health plan; we only mail one packet per household. IPRO response: No change in determination. Updated Policy will be reviewed as part of next year's audit. One welcome packet per household meets this standard.
12.11.2.1.3	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. Contents of the welcome packets shall include those items specified in the Contract. The welcome packet shall include, but is not limited to:	N/A		
12.11.2.1.3.1	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;	Full	CC.MBRS.04 Distribution of New Member Materials shows compliance with this standard.	
12.11.2.1.3.2	A Member Handbook;	Full	CC.MBRS.04 Distribution of New Member Materials 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**
12.11.2.1.3.3	The CCN Member ID Card; and	Full	CC.MBRS.04 Distribution of New Member Materials shows compliance with this standard.	
12.11.2.1.3.4	A Provider Directory (also must be available in searchable format on-line).	Full	CC.MBRS.04 Distribution of New Member Materials shows compliance with this standard.	
12.11.2.3	The CCN shall agree to make available the full scope of core benefits and services to which a member is entitled immediately upon his or her effective date of enrollment, which, with the exception of newborns, will always be the 1st day of a month.	Full	Member Handbook shows compliance with this standard.	
12.11.2.3.1	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	LA.CM.01.03 Health Risk Screening (HRS) Process shows compliance with this standard.	
12.11.2.3.2	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:	N/A		
12.11.2.3.2.1	A brief explanation of the program;	Full	Welcome Call script shows compliance with this standard.	
12.11.2.3.2.2	Statement of confidentiality;	Full	Welcome Call script shows compliance with this standard.	
12.11.2.3.2.3	The availability of oral interpretation and written translation services and how to	Non-Compliance	Welcome Script does not address oral interpretation and written translation services and how to obtain them free of charge.	MCO response: The following language was added to the welcome script: Should you need Interpretation services, we can

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**
	obtain them free of charge;			provide this at no charge. If you would like written translation services, you can call Member Services @ 866-595-8133 and they will be able to assist you with this also free of charge. IPRO response: No change in determination. Updated welcome script will be reviewed as part of next year's audit.
12.11.2.3.2.4	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 instructions about changing PCPs; and	Full	Welcome Script shows compliance with this standard.	
12.11.2.3.2.5	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.	Full	The HRA script is reviewed with the member during the welcome call. Review of the script identified that pregnancy and chronic conditions such as diabetes, COPD, Hypertension, kidney disease, mental health conditions and tobacco use are addressed with the member.	
12.11.2.3.3	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	LA.CM.01.03 Health Risk Screening Process shows compliance with the three outreach attempts. Welcome Script addresses the replacement of the Welcome Packet if not received.	
12.11.2.3.4	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	Full	LA.CM.01.03 Health Risk Screening Process 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**
	successfully make contact.			
12.12	**CCN Member Handbook**			
12.12.1	The CCN shall develop and maintain a member handbook.	Full	Member Handbook shows compliance with this standard.	
12.12.2	Member handbook shall include the following information:	N/A		
12.12.2.1	Table of contents;	Full	Addressed in the Member Handbook.	
12.12.2.2	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	Addressed in the Member Handbook.	
12.12.2.3	Member's right to disenroll from CCN;	Full	Addressed in the Member Handbook.	
12.12.2.4	Member's right to change providers within the CCN;	Full	Addressed in the Member Handbook.	
12.12.2.5	Any restrictions on the member's freedom of choice among CCN providers;	Full	Addressed in the Member Handbook.	
12.12.2.6	Member's rights and protections;	Full	Addressed in the Member Handbook.	
12.12.2.7	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	Addressed in the Member Handbook.	

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**
12.12.2.8	Procedures for obtaining benefits, including prior authorization requirements;	Full	Addressed in the Member Handbook.	
12.12.2.9	Description on the purpose of the Medicaid card and the CCN card and why both are necessary and how to use them;	Full	Addressed in the Member Handbook.	
12.12.2.10	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	Addressed in the Member Handbook. Member Handbook provides members a toll free number to call for specialized behavioral health services that are not covered by the plan.	
12.12.2.11	The extent to which, and how, after-hours and emergency coverage are provided, including:	N/A		
12.12.2.11.1	What constitutes an emergency medical condition, emergency services, and post-stabilization services;	Full	Addressed in the Member Handbook.	
12.12.2.11.2	That prior authorization is not required for emergency services;	Full	Addressed in the Member Handbook.	
12.12.2.11.3	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;	Full	Addressed in the Member Handbook.	
12.12.2.11.4	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	Addressed in the Member Handbook.	
12.12.2.11.5	The locations of any emergency settings and other locations at	Full	Addressed in the Member Handbook.	

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**
	which providers and hospitals furnish emergency services and post-stabilization services covered by the CCN; and			
12.12.2.11.6	That the member has a right to use any hospital or other setting for emergency care.	Full	Addressed in the Member Handbook.	
12.12.2.12	The post-stabilization care services rules;	Full	Addressed in the Member Handbook.	
12.12.2.13	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Full	Addressed in the Member Handbook.	
12.12.2.14	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	Member Handbook and Preferred Drug list found on the plan's website show compliance with this standard.	
12.12.2.15	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	Addressed in the Member Handbook.	
12.12.2.16	For counseling or referral services that the CCN does not cover because of moral or religious objections, the CCN is required to furnish information on how or where to obtain the service;	Full	LA.UM.01.01 Covered Benefits and Services 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
12.12.2.17	Member grievance, appeal and state fair hearing procedures and time frames;	Full	Addressed in the Member Handbook.	
12.12.2.18	Grievance, appeal and fair hearing procedures that include the following:	N/A		
12.12.2.18.1	For State Fair Hearing: The right to a hearing;	Full	Addressed in the Member Handbook.	
12.12.2.18.2	The method for obtaining a hearing; and	Full	Addressed in the Member Handbook.	
12.12.2.18.3	The rules that govern representation at the hearing.	Full	Addressed in the Member Handbook.	
12.12.2.18.4	The right to file grievances and appeals;	Full	Addressed in the Member Handbook.	
12.12.2.18.5	The requirements and timeframes for filing a grievance or appeal;	Full	Addressed in the Member Handbook.	
12.12.2.18.6	The availability of assistance in the filing process;	Full	Addressed in the Member Handbook.	
12.12.2.18.7	The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Full	Addressed in the Member Handbook.	
12.12.2.18.8	The fact that, when requested by the member: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and	Full	Addressed in the Member Handbook.	
12.12.2.18.9	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	Addressed in the Member Handbook.	
12.12.2.18.10	In a State Fair Hearing, the Division	Full	Addressed in the Member Handbook.	

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.			
12.12.2.19	Advance Directives. A description of advance directives which shall include:	N/A		
12.12.2.19.1	The CCN policies related to advance directives;	Full	Addressed in the Member Handbook.	
12.12.2.19.2	The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;	Full	Addressed in the Member Handbook.	
12.12.2.19.3	Information that members can file complaints about the failure to comply with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and	Full	Addressed in the Member Handbook.	
12.12.2.19.4	Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.	Non-Compliance	CC.CM.10 Advance Directives does not address where members can seek assistance in the execution of advance directives and to whom copies should be given. Policy should include guidance for members to find assistance in executing an advance directive and to whom copies should be given.	MCO response: Health plan added language in policy CC.CM.10 related to advanced directive execution assistance and copy distribution. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's audit.

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**
12.12.2.20	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	Addressed in the Member Handbook.	
12.12.2.21	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Full	Addressed in the Member Handbook.	
12.12.2.22	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Full	Addressed in the Member Handbook.	
12.12.2.23	How to obtain emergency and non-emergency medical transportation;	Full	Addressed in the Member Handbook.	
12.12.2.24	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Full	Addressed in the Member Handbook.	
12.12.2.25	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	Addressed in the Member Handbook.	
12.12.2.26	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported the CCN;	Full	Addressed in the Member Handbook.	

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**
12.12.2.27	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	Addressed in the Member Handbook.	
12.12.2.28	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	Addressed in the Member Handbook.	
12.12.2.29	Information on the member's right to a second opinion at no cost and how to obtain it;	Full	Addressed in the Member Handbook.	
12.12.2.30	Any additional text provided to the CCN by DHH or deemed essential by the CCN;	N/A		
12.12.2.31	The date of the last revision;	Full	Addressed in the Member Handbook.	
12.12.2.32	Additional information that is available upon request, including the following: information on the structure and operation of the CCN; physician incentive plans; service utilization policies; and how to report alleged marketing violations to DHH utilizing the Marketing	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**
	Complaint Form.			
12.13	**Member Identification (ID) Card**			
12.13.1	CCN members will receive two (2) member identification cards.	Full	Addressed in the Member Handbook.	
12.13.1.1	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.	Full	DHH issued ID cards.	
12.13.1.2	A CCN issued member ID card that contains information specific to the CCN. 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, address and telephone numbers (including after-hours number, if different from business hours number); and The toll-free number(s) for: 24-hour Member Services and Filing Grievances, Provider Services and Prior	Full	A-LHC Member ID Card and Cover Letter 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**
	Authorization and Reporting Medicaid Fraud (1-800-488-2917).			
12.13.2	The CCN shall issue the CCN Member ID card with the welcome packet. As part of the card mailing, 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	Addressed in the Member Handbook.	
12.13.3	The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.	Full	A-LHC Member ID Card (RX) and Cover Letter shows compliance with this standard.	
12.13.4	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 card.	Full	Member letter sent with Member ID Card shows explanation of why old ID Card is being replaced with new ID Card.	
12.13.5	The CCN shall reissue the CCN ID card within ten (10) calendar days 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.	Full	Member Handbook shows compliance with this standard.	
12.13.6	The holder of the member identification card issued by the CCN shall be a CCN member or	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**
	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.			
12.13.7	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	Nurtur Service Agreement submitted. Vendor agreement reviewed. Section 2.10 Nondiscrimination shows compliance with standard.	
12.14	**Provider Directory for Members**			
12.14.1	The CCN shall develop and maintain a Provider Directory in four (4) formats:	N/A		
12.14.1.1	A hard copy directory for members and upon request, potential members;	Full	LA.MBRS.01 shows compliance with this standard.	
12.14.1.2	Web-based, searchable, online directory for members and the public; and	Full	LA.PRVR.19 Provider Directory and Electronic Files from Portico shows compliance with this standard.	
12.14.1.3	Electronic file of the directory for the Enrollment Broker.	Full	LA.PRVR.19 Provider Directory and Electronic Files from Portico shows compliance with this standard.	
12.14.1.4	Hard copy, abbreviated version for the Enrollment Broker.	Non-Compliance	An abbreviated version for the Enrollment Broker was not located. Plan should include a hard copy, abbreviated version of the member's Provider Directory for the Enrollment Broker.	MCO response: Updated provider directories are currently being developed and abbreviated versions by region will be provided to the Enrollment Broker upon completion. IPRO 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**
				No change in determination. Evidence of distribution of the provider directory to the Enrollment Broker will be reviewed as part of next year's audit.
12.14.2	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.	N/A		
12.14.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly 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 electronic version shall be updated prior to each submission to DHH's Fiscal Intermediary. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to new Medicaid enrollees. Format for this version will be in a format specified by DHH.	Full	LA.PRVR.19 Provider Directory and Electronic Files from Portico shows compliance with this standard.	
12.14.4	The provider directory shall include, but not be limited to:	N/A		
12.14.4.1	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the	Full	Provider Directories submitted and reviewed show 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**
	Medicaid enrollee's service area, including identification of providers, PCPs, specialists, and hospitals at a minimum, that are not accepting new patients;			
12.14.4.2	Identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area;	Full	Provider Directories submitted and reviewed show compliance with this standard.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Full	Member Handbook shows compliance with this standard.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	Full	Provider Directories submitted and reviewed show compliance with this standard.	
12.15	**Member Call Center**			
12.15.1	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:	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.1	Explanation of CCN policies and procedures;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.2	Prior authorizations;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.3	Access information;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.4	Information on PCPs or specialists;	Full	LA.MSPS.22 Member Service Calls/Hotline 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**
12.15.1.5	Referrals to participating specialists;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.6	Resolution of service and/or medical delivery problems; and	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.1.7	Member grievances.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.2	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.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.3	The toll-free line shall have an automated system, available 24-hours 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 has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.15.4	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	Full	LA.MSPS.22 Member Service Calls/Hotline 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**
	performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.			
12.15.5	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	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard. Alternate Site Plan of Business Continuity Plan 2013-14 submitted. MCO explained that overflow calls are rerouted to predetermined backup routes located in Atlanta, GA and Jackson, MS.	
12.15.6	The CCN must develop telephone help line policies and procedures that address staffing, personnel, 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	Full	LA.MSPS.22 Member Service Calls/Hotline 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**
	record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.			
12.15.7	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	CC.MSPS.24 Member & Provider Call Audit and Quality Criteria and Protocol shows compliance with this standard.	
12.16	**ACD System**			
12.16.1	The CCN shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:	N/A		
12.16.1.1	Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.2	Transfer calls to other telephone lines;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.2.1	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	LA.MSPS.22 Member Service Calls/Hotline 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
12.16.1.3	Provide a message that notifies callers that the call may be monitored for quality control purposes;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.4	Measure the number of calls in the queue at peak times;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.5	Measure the length of time callers are on hold;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.5.1	Measure the total number of calls and average calls handled per day/week/month;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.6	Measure the average hours of use per day;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.7	Assess the busiest times and days by number of calls;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.8	Record calls to assess whether answered accurately;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.8.1	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 telephone lines are not disrupted;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.8.2	Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.1.9	Inform the member to dial 911 if there is an emergency.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2	Call Center Performance Standards	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.1	Answer ninety (90) percent of calls within thirty (30) seconds or an	Full	LA.MSPS.22 Member Service Calls/Hotline 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**
	automatic call pickup system;			
12.16.2.2	No more than one percent (1%) of incoming calls receive a busy signal;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.3	Maintain an average hold time of three (3) minutes or less;	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.4	Maintain abandoned rate of calls of not more than five (5) percent.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.4.1	The CCN must conduct ongoing quality assurance to ensure these standards are met.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.4.2	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.	Full	LA.MSPS.22 Member Service Calls/Hotline shows compliance with this standard.	
12.16.2.5	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 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.	Full	LA.MBRS.25 Member Rights and Responsibilities shows compliance with this standard.	
12.16.3	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Full	Addressed in the Member Handbook.	
12.16.4	**Member Responsibilities**			

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**
12.16.4.1	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	Addressed in the Member Handbook.	
12.16.4.2	The CCN members' responsibilities shall include but are not limited to:	N/A		
12.16.4.2.1	Informing the CCN of the loss or theft of their ID card;	Full	Addressed in the Member Handbook.	
12.16.4.2.2	Presenting their CCN ID card when using health care services;	Full	Addressed in the Member Handbook.	
12.16.4.2.3	Being familiar with the CCN procedures to the best of the member's abilities;	Full	Addressed in the Member Handbook.	
12.16.4.2.4	Calling or contacting the CCN to obtain information and have questions answered;	Full	Addressed in the Member Handbook.	
12.16.4.2.5	Providing participating network providers with accurate and complete medical information;	Full	Addressed in the Member Handbook.	
12.16.4.2.6	Asking questions of providers to determine the potential risks,	Full	Addressed in the Member Handbook.	

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**
	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;			
12.16.4.2.7	Living healthy lifestyles and avoiding behaviors know to be detrimental to their health;	Full	Addressed in the Member Handbook.	
12.16.4.2.8	Following the grievance process established by the CCN if they have a disagreement with a provider; and	Full	Addressed in the Member Handbook.	
12.16.4.2.9	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.	Full	Addressed in the Member Handbook.	
12.17	**Notice to Members of Provider Termination**			
12.17.1	The CCN shall make a good faith effort to give written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider	Full	Member Handbook and LA.MBRS.27_Attachment A Term Notice show compliance with this standard.	
12.17.2	The CCN shall provide notice to a member, who has been receiving a	Full	Addressed in the Member Handbook.	

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**
	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.			
12.17.3	Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the CCN, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the CCN becoming aware of the circumstances.	Full	LA.MBRS.27 Member Advisory of Provider Termination shows compliance with this standard.	
121.8	**Additional Member Educational Materials and Programs**			
12.8.0	The CCN shall prepare and distribute educational materials, including, but not limited to, the following:	N/A		
12.18.1	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Full	Samples of member newsletters submitted. The plan sends them four times per year.	
12.18.2	Literature, including brochures and posters, such as calendars and	Full	LA.MRKT.02 Marketing and Member Education Plan submitted along with literature shows compliance with	

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**
	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;		this standard.	
12.18.3	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Full	Education materials submitted for the following: Diabetes for adults, children and teens, PAD, Cholesterol, Hypertension, Stress, weight management, Asthma, Pregnancy show compliance with this standard.	
12.18.4	Materials focused on health promotion programs available to the members;	Full	Health promotion programs submitted for review: Physical activity, Smoking Cessation, Health Heart, Weight Management show compliance with this standard.	
12.18.5	Communications detailing how members can take personal responsibility for their health and self management;	Full	Addressed in the Member Handbook.	
12.18.6	Materials that promote the availability of health education classes for members;	Full	Documents submitted for member classes, Pregnancy for Moms and Dads to be show compliance with this standard.	
12.18.7	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Full	LA.CM.02 Chronic Care (Disease) Management Programs show compliance with this standard.	
12.18.8	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	LA.CM.02 Chronic Care (Disease) Management Program. Nurtur, administers the chronic care management program show compliance with this standard. Reviewed educational materials on-site.	
12.18.9	Notification to its members their right to request and obtain the	Full	Addressed in the Member Handbook.	

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**
	welcome packet at least once a year;			
12.18.10	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	Full	Addressed in the Member Handbook.	
12.18.11	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	Full	CC.MBRS.04 Distribution of New Member Materials shows compliance with this standard.	
12.19	**Oral and Written Interpretation Services**			
12.19.1	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	CC.MBRS.15 Interpreter Services for Scheduled Medical Appointments shows compliance with this standard.	
12.19.2	The CCN shall ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members	Full	CC.MBRS.02 Member Materials Readability and Translation reviewed. Threshold languages: the non-English languages spoken by at least 5% of the population in the service area or 3,000 people, whichever is fewer (or as otherwise defined by State contract, whichever is most strict).	

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 a CCN within the GSA. Within 90 calendar days of notice from DHH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately.			
12.20	**Marketing Reporting and Monitoring**			
12.20.1	Reporting to DHH:	N/A		
12.20.1.1	The CCN must provide a monthly report in a format prescribed by DHH (See Appendix BB, Marketing Plan Monthly Report) 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.	Full	Marketing & Member Education Bayou Health Reporting document reviewed and shows compliance with this standard.	
12.20.1.2	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.	Full	LHC PM109 Marketing and Member Education report shows compliance with this standard.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
13.0	**Member Grievance and Appeals Procedures**			
13.0.1	The CCN must have a grievance system. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with all applicable state and federal laws.	Full	Addressed in QI 11 and QI.11.01 – Grievance System and Grievance Process.	
13.0.2	The CCN's grievance and appeals procedures and any changes thereto must be approved in writing by DHH prior to their implementation and must include at a minimum the requirements set forth in this RFP.	Full	Addressed in QI 11 – Grievance System.	
13.0.3	The CCN shall refer all CCN members who are dissatisfied with the CCN or its subcontractor in any respect to the CCN's designee authorized to review and respond to grievances and appeals and require corrective action.	Full	Addressed in QI 11 – General Requirements of the Grievance System.	
13.0.4	The member must exhaust the CCN's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	Full	Addressed in QI 11 – General Requirements of the Grievance System.	
13.0.5	The CCN shall not create barriers to timely due process. The CCN shall be subject to sanctions if it is determined by DHH that the CCN has created barriers to timely due process, and/or, if ten (10) percent	Full	Addressed in QI 11. Examples of barriers noted in the contract are cited.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	or higher of grievance decisions appealed to the State Fair Hearing level within a twelve (12) month period have been reversed or otherwise resolved in favor of the member. Examples of creating barriers shall include but not be limited to: including binding arbitration clauses in CCN member choice forms; labeling complaints as inquiries and funneled into an informal review; failing to inform members of their due process rights; failing to log and process grievances and appeals; failure to issue a proper notice including vague or illegible notices; failure to inform of continuation of benefits; and failure to inform of right to State Fair Hearing.			
13.1	**Applicable Definition**			
13.1.1	Definition of Action - An action is defined as: the denial or limited authorization of a requested service, including the type or level of service; or the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service; or the failure to provide services in a timely manner; or the failure of the CCN to act within the timeframes provided.	Full	Defined in Grievance System Policy 11.01.	
13.1.2	Definition of Appeal - An appeal is	Full	Defined in Grievance System Policy 11.01.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	defined as a request for review of an action.			
13.1.3	Definition of Grievance - A grievance is defined as 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 grievances and appeals handled at the CCN level.	Full	Defined in Grievance System Policy 11.01.	
13.2	**General Grievance System Requirement**			
13.2.1	Grievance System. The CCN must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the CCN's appeal process has been exhausted.	Full	Addressed in QI 11 and QI.11.01 – Grievance System and Grievance Process.	
13.2.2	Filing Requirements	N/A		
13.2.2.1	Authority to File	N/A		
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and a CCN level appeal,	Full	Addressed in QI.11.01 – Grievance Process.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	and may request a State Fair Hearing, once the CCN's appeals process has been exhausted.			
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	Full	Addressed in QI.11.01 – Grievance Process.	
13.2.3	Time Limits for Filing. The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action or inaction to file a grievance or appeal. Within that timeframe the member or a representative acting on their behalf may file an appeal or the provider may file an appeal on behalf of the member, and with the member's written consent.	Full	Addressed in QI.11.01 – Grievance Process.	
13.2.4	Procedures for Filing. The member may file a grievance either orally or in writing with the CCN. The member or a representative acting on their behalf, or the provider, acting on behalf of the member and with the member's written consent, may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.	Full	Policy addressed in QI.11.01 – Grievance Process.	
13.3	**Notice of Grievance and Appeal Procedures**			

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
13.3.1	The CCN shall ensure that all CCN members are informed of the State Fair Hearing process and of the CCN's grievance and appeal procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance and appeal procedures. Forms on which members may file grievances, appeals, 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.	Substantial	Addressed in QI.11.01 – Grievance Process. Grievance form for members was developed. Member Handbook includes a description of the grievance process. In the file review of a sample of Appeals, the letter to the member did not include a statement that the member has a right to see his/her case file and medical records. However, this opportunity was made available regarding the State Fair Hearing Process.	MCO response: A statement will be added to the member appeals letter that explains to the member that he/she has a right to see any of his/her case files and medical records that are utilized for the appeals process. IPRO response: No change in determination. Updated member appeals letter will be reviewed as part of next year's file review.
13.4	**Grievance/Appeal Records and Report**			
13.4.1	The CCN must maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	Full	Addressed in QI.11 Grievance System.	
13.4.2	The CCN shall electronically provide	Full	Monthly grievance reports are prepared that indicate	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	DHH with a monthly report of the grievances/appeals in accordance with the requirements outlined in this RFP, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. Reports with personally identifying information redacted will be made available for public inspection.		members who filed grievances each month and their resolution. Summaries are provided.	
13.4.3	The CCN will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the CCN member. DHH may submit recommendations to the CCN regarding the merits or suggested resolution of any grievance/appeal.	Full	Addressed in QI11.01 Grievance System.	
13.5	**Handling of Grievances and Appeal**			
13.5.1	General Requirements - In handling grievances and appeals, the CCN must meet the following requirements:	N/A		
13.5.1.1	Acknowledge receipt of each grievance and appeal in writing;	Substantial	Both oral and written grievances should be acknowledged in writing within 5 business days as per QI11.01, Grievance Process. In the review of 20 member grievances, two did not have an acknowledgement letter in the file.	MCO response: The grievance/appeals process will be reviewed to ensure that acknowledgement letters will be written and mailed in response to all grievances/appeals submitted to the Plan in a timely manner. IPRO response: No change in determination. Updated process will be

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
				reviewed as part of next year's audit.
13.5.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	Full	Addressed in QI.11.01 Grievance Process.	
13.5.1.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by DHH, in treating the member's condition or disease: an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance or appeal that involves clinical issues.	Minimal	Policy addressed in QI11.01 Grievance System. In the review of Informal Reconsideration sample files, though it was apparent from reviewing the letter to the facility/member that the plan reviewer was clinical and most often the plan Medical Director, the review form did not have a field for Reviewer credentials. It would be worthwhile to include credentials in a new field or incorporate it into the existing "Review Type" field. In the case review, 5 of 20 cases did not have documentation of investigation other than speaking to the member when speaking to the provider would have been warranted as well.	MCO response: The Plan will ensure that the review form includes the Reviewer credentials to demonstrate that a health care professional with the appropriate clinical expertise was utilized to conduct the review process. The Plan will educate the Grievance Coordinator to include the documentation of all communication conducted during the investigation of the grievance. This will include any communication with the provider directly or communication where the Provider Relations Representative spoke with the provider on the plan's behalf. IPRO response: No change in determination. Updated review form will be reviewed as part of next year's audit to ensure it contains a field for "reviewer credentials." Evidence of an investigation will also be evaluated.
13.5.2	Special Requirements for Appeals The process for appeals must:	N/A		
13.5.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal)	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	and must be confirmed in writing, unless the member or the provider requests expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.			
13.5.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The CCN must inform the member of the limited time available for this in the case of expedited resolution).	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.5.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.5.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	Substantial	Addressed in Policy UM 08 Appeal of UM Decisions. Policy notes that the representative of a deceased member should be included. The section should clarify that the person must be the “legal” representative of the deceased as per the contract language.	MCO response: LA.UM.08 Appeal of UM Decision. Health plan added word ‘legal’ to page 3 to meet standard. IPRO response: No change in determination. Updated policy will be reviewed as part of next year’s audit.
13.5.3	Training of CCN Staff - The CCN's staff shall be educated concerning	Full	Addressed in Policy UM 08 Appeal of UM Decisions and QI11.01 Grievance System.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	the importance of the grievance and appeal procedures and the rights of the member and providers.			
13.5.4	Identification of Appropriate Party - The appropriate individual or body within the CCN having decision making authority as part of the grievance/appeal procedure shall be identified.	Full	Addressed in QI11.01 Grievance System. A Grievance System Coordinator is the responsible staff person.	
13.5.5	Failure to Make a Timely Decision - Appeals shall be resolved no later than stated time frames and all parties shall be informed of the CCN's decision. If a determination is not made in accordance with the timeframes specified in 13.7, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.5.6	Right to State Fair Hearing - The CCN shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the CCN's decision in response to an appeal and the process for doing so.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6	**Notice of Action**			
13.6.1	Language and Format Requirements - The notice must be in writing and must meet the language and format requirements to ensure ease of	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	understanding.			
13.6.2	Content of Notice of Action - The Notice of Action must explain the following:	N/A		
13.6.2.1	The action the CCN or its contractor has taken or intends to take;	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.2	The reasons for the action;	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.3	The member's or the provider's right to file an appeal with the CCN;	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.4	The member's right to request a State Fair Hearing, after the CCN's appeal process has been exhausted;	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.5	The procedures for exercising the rights specified in this section;	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.6	The circumstances under which expedited resolution is available and how to request it; and	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.3	Timing of Notice of Action The CCN must mail the Notice of Action within the following timeframes:	N/A		
13.6.3.1	For termination, suspension, or reduction of previously authorized	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	Medicaid-covered services, at least ten (10) days before the date of action.			
13.6.3.2	For denial of payment, at the time of any action affecting the claim.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.3.3	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: the member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.3.4	If the CCN extends the timeframe in accordance with it must: give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
13.6.3.5	On the date the timeframe for service authorization expires.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.3.6	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 Policy UM 08 Appeal of UM Decisions.	
13.6.3.7	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 interest.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.6.3.8	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.	N/A		
13.7	**Resolution and Notification**			
13.7	The CCN must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously	N/A		

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	as the member's health condition requires, within the timeframes established in 13.7.1 below.			
13.7.1	Specific Timeframes	N/A		
13.7.1.1	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.	Full	Addressed in QI 11.01 Grievance System. All must be resolved within 90 days and most are resolved within 10 days.	
13.7.1.2	Standard Resolution of Appeals. For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the CCN receives the appeal. This timeframe may be extended under 13.7.2 of this section.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.7.1.3	Expedited Resolution of Appeals. For expedited resolution of an appeal and notice to affected parties, the timeframe is established as seventy-two (72) hours after the CCN receives the appeal. This timeframe may be extended under 13.7.2 of this Section.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.7.2	Extension of Timeframes. The CCN may extend the timeframes from 13.7.1 of this section by up to fourteen (14) calendar days if: the member requests the extension; or	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	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. 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.			
13.7.3	Format of Notice of Disposition Grievances. DHH will specify the method the CCN will use to notify a member of the disposition of a grievance. Appeals. For all appeals, the CCN must provide written notice of disposition. For notice of an expedited resolution, the CCN must also make reasonable efforts to provide oral notice.	Substantial	Addressed in Policy UM 08 Appeal of UM Decisions and in QI 11.01 Grievance System. Three of 20 grievance cases reviewed did not have a resolution letter in the file.	MCO response: The grievance/appeals process will be reviewed to ensure that resolution letters will be written and mailed in response to all grievances submitted to the Plan in a timely manner. IPRO response: No change in determination. Updated policy will be reviewed as part of next year's file review.
13.7.4	Content of Notice of Appeal Resolution. The written notice of the resolution must include the following: the results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	upholds the CCN's action.			
13.7.5	Requirements for State Fair Hearings The CCN shall comply with all requirements as outlined in this RFP.	N/A		
13.7.5.1	Availability. If the member has exhausted the CCN level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the CCN's notice of resolution.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.7.5.2	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 Policy UM 08 Appeal of UM Decisions.	
13.8	**Expedited Resolution of Appeals**			
13.8.0	The CCN must establish and maintain an expedited review process for appeals, when the CCN determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	maximum function.			
13.8.1	Prohibition Against Punitive Action The CCN must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.8.2	Action Following Denial of a Request for Expedited Resolution - If the CCN denies a request for expedited resolution of an appeal, it must: transfer the appeal to the timeframe for standard resolution in accordance with Section 13.7.1.2.; make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.8.3	Failure to Make a Timely Decision - Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the CCN's decision. If a determination is not made by the above timeframes, the member's request will be deemed to have been approved as	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	of the date upon which a final determination should have been made.			
13.8.4	Process - The CCN is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required. The CCN shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.8.5	Authority to File - The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.8.6	Format of Resolution Notice - In addition to written notice, the CCN must also make reasonable effort to provide oral notice.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.9	**Continuation of Benefits**			

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
13.9.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the CCN mailing the notice of action. The intended effective date of the CCN's proposed action.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.9.2	Continuation of Benefits - The CCN must continue the member's benefits if: the member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of benefits.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.9.3	Duration of Continued or Reinstated Benefits - If, at the member's request, the CCN continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: the member withdraws the appeal. Ten (10) days pass after the CCN mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
	(10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached. A State Fair Hearing Officer issues a hearing decision adverse to the member. The time period or service limits of a previously authorized service has been met.			
13.9.4	Member Responsibility for Services Furnished While the Appeal is Pending - If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the CCN 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.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.10	**Information to Providers and Contractors**			
13.10	The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract.	Full	The plan's Grievance system and process is outlined in detail in the Provider Manual.	
13.11	**Recordkeeping and Reporting Requirements**			
13.11	Reports of grievances and resolutions shall be submitted to DHH as specified in 13.4.The CCN shall not modify the grievance procedure without the prior written approval of DHH.	Full	Monthly grievance reports are prepared and submitted.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulation: 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**
13.12	**Effectuation of Reversed Appeal Resolutions**			
13.12.1	Services not Furnished While the Appeal is Pending - If the CCN or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCN must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	
13.12.2	Services Furnished While the Appeal is Pending - If the CCN or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCN must pay for those services, in accordance with this Contract.	Full	Addressed in Policy UM 08 Appeal of UM Decisions.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**			
14.1.1	The CCN shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program to:	N/A		
14.1.1.1	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	Full	The QAPI Program Description includes monitoring and evaluation of quality and appropriateness of care and services in its description of scope and objectives. P/P LA.QI.17 Monitoring Quality of Care and P/P CC.QI.18 Quality of Care Investigations outline the process for identifying, monitoring and addressing potential quality of care issues. The plan provided evidence of objective and systematic monitoring and evaluation in the2012 Annual Quality Assessment Performance Improvement Program Evaluation (QAPI Program Evaluation), which includes trending of grievances and appeals by category, provider satisfaction, service call metrics, potential quality of care issues by outcome, and after-hours provider access. A summary of delegation oversight is also included in the QAPI Program Evaluation. The 2012 Utilization Management Program Evaluation (UM Program Evaluation) documents evidence of tracking of metrics including case management enrollment, obstetric measures, Each focus area in the QAPI and UM Program Evaluations includes an assessment of findings, identified barriers and action plan. The plan also provided several reports documenting monitoring of quality of care and services, including the LA 526 CMS 416 quarterly EPSDT screening and participation rate report and PCP profiling reports. The plan provided evidence of an ongoing medical record audit that has begun and is slated to be completed December 22, 2013. Results are to be scored and	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			trended. The plan provided evidence of tracking of preliminary HEDIS 2014 measures, with monthly tracking of rates and comparison to Quality Compass benchmarks. Further evidence of objective and systematic monitoring and evaluation can be found in the Performance Improvement Team (PIT) Quarterly Meeting Summary of July 18, 2013 that the plan provided onsite; this summary includes a list of DHH performance measures with data source and activities relevant to the measures and results of PCP profiling for adolescent well visits.	
14.1.1.2	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; and surveys	Full	The plan has incorporated performance improvement projects into the program, and provided PIP status reports for Reduction of Inappropriate ER Utilization and Increasing Cervical Cancer Screening. The plan also describes departmental performance improvement projects in the QAPI Program Evaluation, including increasing Notifications of Pregnancy and the number of pregnant women and high risk pregnant members enrolled in Start Smart for Your Baby, assisting PCPs with reaching members who habitually miss appointments, and a project centered on education and support to members with NICU babies. The plan has incorporated performance measurement, including current tracking of HEDIS measures as described above, into the program. The plan provided Complex Case Management Effectiveness Reports which document actions implemented to improve receipt of 17 hydroxyprogesterone by eligible pregnant women, receipt of flu vaccine and hydroxyurea for members with sickle cell disease. The plan currently has a CAHPS survey underway and has conducted a provider survey. The plan has implemented medical record audits as	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			described above, which monitor documentation including EPSDT required elements for visits. The PIT summary referenced the plan's NCQA/HEDIS task force that is focusing on Level 1 DHH measures, and outreaching to non-compliant members for breast and cervical cancer screening, Chlamydia screening and EPSDT services.	
14.1.1.3	Detect underutilization and overutilization of services	Full	P/P UM.01.03 Monitoring Utilization describes processes for monitoring and detecting underutilization and overutilization of services.The UM Program Evaluation includes reports of inpatient stays, inpatient length of stay, outpatient visits, emergency department (ED) utilization, obstetric average length of stay, NICU admissions, cesarean section rates and use of 17 hydroxyprogesterone to reduce recurrent preterm. The plan provided reports tracking these metrics as well as inpatient bed level (e.g. ICU level of care), inpatient stay use by foster children and SSI recipients, readmission, pharmacy and Primary Care Provider (PCP) and specialist visits. The PIT quarterly meeting summary refers to tracking antipsychotic drug use, which was confirmed by onsite staff.	
14.1.1.4	Assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Full	The plan's QAPI Program Description includes monitoring, analysis and improvement of health care for all members, including those with special health care needs, as objectives, and results are to be part of the program evaluation. The UM Program Description includes a description of Complex Case Management to meet individuals' needs. High risk members, including children and adults with special health care needs, including high risk comorbidities, are referred to this Complex Case Management. The plan provided P/P LA.CM.06 Predictive Modeling Education/Training Email: Trigger List for Potential CM Referrals, which includes processes for identifying members with special needs, and LA.UM.16.01 Referral to Specialty Health Care Services, which addresses referrals to specialty health care services, training	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 on identification, screening and referral of members with behavioral health needs, facilitation of communication between specialists and PCPs, and provider referral for chronic care and case management services. The UM Program Evaluation includes monitoring of members with diabetes, asthma, hypertension and heart failure in Disease Management. As noted above flu vaccine and measures for at-risk pregnant women and members with sickle cell are also being monitored by the plan as documented in the Complex Case Management Effectiveness Measures Reports for the 17P, Sickle Cell and Fluvention (Flu Prevention) Programs. These reports document baseline measure rates for these measures and actions to address barriers. The onsite staff also provided information on Connectionsplus, a program for pregnant and high risk members with special healthcare needs that includes home visits and preprogrammed cell phones.	
14.1.2	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	Full	Processes for ongoing monitoring are outlined in the QAPI Program Description, which documents QAPI goals to include guideline compliance for asthma, diabetes, chronic kidney disease detection, prenatal care and immunizations. P/P LAQI.08 Preventive Health and Clinical Care Guidelines describes processes for adoption and dissemination of guidelines, including guidelines for ADHD, diabetes, asthma, sickle cell disease, lead screening, perinatal and preventive care. The policy indicates that care consistent with guidelines will be measured annually; as per onsite staff, this will be evaluated with HEDIS and Complex Case Management Effectiveness of Care Measures. The medical record audit tool also includes guideline-specific elements that are monitored in the medical record audits currently underway. PCP profiling reports were also provided, including monitoring for cervical cancer and Chlamydia screening and EPSDT rates.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 plan's current QAPI activities include high risk, high volume areas of care, such as recurrent preterm prevention, sickle cell disease, and cancer screening.	
14.1.3	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.	Full	The plan provided evidence of process improvements in PIP status reports, the QAPI Program Evaluation, UM Program Evaluation and Work Plans, as well as in the Complex Case Management Effectiveness of Care Measure Reports. These reports and Program Evaluations include assessments of results and development of actions to address barriers to appropriate care and utilization. As noted above, process improvement initiatives include but are not limited to reducing avoidable emergency department use, increasing cancer screening, increasing appropriate care for members with sickle cell disease, increasing flu vaccination, and preventing recurrent preterm birth.	
14.1.4	The CCN shall submit its QAPI Program description to DHH for written approval within thirty (30) days from the date the Contract is signed.	N/A		
14.1.5	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 QAPI Program Description identifies LHC's Board of Directors as responsible for oversight of the quality of care and services received by members and the development, implementation and evaluation of the QAPI Program. Operating authority is delegated to the QAPI Committee, which provides direction to a plan wide system of monitoring, evaluation and improvement, and the program structure is described as incorporating quality throughout LHC operations.	
14.2	**QAPI Committee**			
14.2.1	The CCN shall form a QAPI Committee that shall, at a minimum include: QAPI Committee Members	Full	As per the QAPI Program Description, the plan has established the Quality Assessment and Performance Improvement Committee (QAPIC) that provides direction and oversight to the assessment and	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			improvement of the quality of care and services provided to members.	
14.2.1.1	The CCN Medical Director must serve as either the chairman or co-chairman;	Full	The QAPIC is chaired or co-chaired by the chief medical director as per the QAPI Program Description. Minutes of QAPIC meeting reveal the meetings are chaired by the plan's Medical Director.	
14.2.1.2	Appropriate CCN staff representing the various departments of the organization will have membership on the committee; and	Full	As per the QAPIC Program Description and meeting minutes, as well as the LA QAPIC Committee Charter, the QAPIC is a multidisciplinary committee and members include the CEO, Chief Medical Officer, Directors of Medical Management and Quality Improvement, Manager of Provider Services/Contracts, Member Services, Grievances and Complaints, Compliance, Finance and network provider and member advocate representatives.	
14.2.1.3	The CCN is encouraged to include a member advocate representative on the QAPI Committee.	Full	QAPI Committee members include a member advocate representative as per the QAPI Program Description.	
14.2.2	QAPI Committee Responsibilities	N/A	Responsibilities of the QAPI Committee are outlined in the QAPI Program Description.	
14.2.2.1	The committee shall meet on a quarterly basis;	Substantial	As per the QAPI Program Description, the QAPIC is to meet no less than quarterly. Minutes provided by the plan reveal that three meetings occurred in 2012 (3/27/12, 5/31/12, and 7/19/12). The meeting scheduled for 10/18/12, for which an agenda was provided but not minutes, was not held due to change in medical director as per the QAPI Program Evaluation. A make- up meeting was scheduled for 1/13/13 and held but as per the minutes there was no official quorum for the meeting. Minutes were also provided for QAPIC meeting on 4/29/13, 7/26/13. Onsite staff indicated the quarterly QAPIC meetings are currently on track.	MCO response: The QAPI Committee will meet all meeting frequency requirements going forward as stated in the committee charter. As required by the state contract and the committee charter, the QAPIC committee will meet on a quarterly basis. IPRO response: No change in determination. Committee meeting minutes will be reviewed as part of next year's audit to ensure that the quarterly frequency contractual requirements are being met.
14.2.2.2	Direct and review quality improvement (QI) activities;	Full	As per the QAPI Program Description, the QAPIC purpose is to provide oversight and direction to the program, and meeting minutes reveal active review of	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			QI activities.	
14.2.2.3	Assure than QAPI activities are implemented throughout the CCN;	Full	As per the QAPI Program Description, the QAPIC implements a plan-wide system of monitoring, evaluation and improvement, and reporting findings to staff, departments and the Board of Directors. Minutes of QAPIC meetings demonstrate participation of departments across the plan in QAPI activities. As per the QAPI Program Description, the Performance Improvement Team (PIT), a cross functional team, facilitates a quality improvement culture across the organization.	
14.2.2.4	Review and suggest new and or improved QI activities;	Full	The LA QAPIC Committee Charter includes as an objective making recommendations to subcommittees on monitoring, follow-up, barrier analysis and interventions required to improve care and services. The PIT, which reports to the QAPIC, analyzes data and conducts barrier analysis and recommends improvement activities/corrective actions, and implements actions recommended by the QAPIC. Minutes of the QAPIC include reviews of PIPs and other QI activities.	
14.2.2.5	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	Full	The QAPI Program Description includes this language as within the scope of the QAPIC. Minutes demonstrate compliance.	
14.2.2.6	Designate evaluation and study design procedures;	Full	Per the QAPIC Committee Charter, the QAPIC reviews clinical quality recommendations from subcommittees, and makes recommendations for follow-up, barrier analysis and interventions. The QAPIC prioritizes study initiatives and helps define the study question, indicators, criteria and goals. QAPIC minutes include discussion of performance improvement initiatives.	
14.2.2.7	Conduct individual PCP and PCP practice quality performance measure profiling;	Full	P/P CC.QI.22 Provider Profiling outlines the process for generating provider profiling reports, and evaluation of provider profiles is within the scope of the QAPIC as per the QAPI Program Description. The QAPI conducts ongoing evaluation of appropriateness and	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	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
			effectiveness of practice profiling. The plan provided several provider profile reports for review, including utilization, cervical cancer screening, Chlamydia screening and EPSDT reports.	
14.2.2.8	Report findings to appropriate executive authority, staff, and departments within the CCN;	Full	As per the QAPIC Program Description, the QAPIC scope includes reporting findings to the Board of Directors (BOD), staff and departments within the plan. The QAPIC submits minutes and summary of effectiveness of program to the Board of Directors, and reports were submitted as per the 2012 QAPI Work Plan February 2013.	
14.2.2.9	Direct and analyze periodic reviews of members' service utilization patterns;	Full	The Utilization Management Committee monitors utilization service patterns, which are routinely reported to QAPIC as per the QAPI Program Description and as reflected in QAPIC minutes.	
14.2.2.10	Maintain minutes of all committee and sub-committee meetings and submit meeting minutes to DHH within ten (10) business days following each meeting;	Full	As per the QAPI Program Description the QAPIC maintains detailed records and minutes of all QAPIC committee meetings and submits to DHH within 10 business days of meeting. Minutes of all meetings were provided for review.	
14.2.2.11	Report an evaluation of the impact and effectiveness of the QAPI program to DHH annually. This report shall include, but is not limited to, all care management activities; and	Full	The plan provided the 2012 Annual Quality Assessment and Performance Improvement Program Evaluation, which as per the QAPI Program Description is submitted annually to DHH following approval by the BOD, for review. The QAPI Program Evaluation and the Utilization Management Program Evaluation include evaluations of care management activities. The QAPI Program Evaluation also includes an analysis of demographics, work of the CLAS task force, PIP results, disease management measures, obstetric outcomes and utilization metrics with analysis of findings, barriers, and actions.	
14.2.2.12	Ensure that a QAPI committee designee attends DHH Quality Committee meetings.	Full	As per the QAPI Program Description a member of the QAPIC regularly attends DHH Quality Committee meetings and reports back to QAPIC. Onsite staff indicated the Chief Medical Officer attend Quality Committee meetings.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.2.3	QAPI Work Plan: The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the CCN and annually thereafter, and prior to revisions. The QAPI plan, at a minimum, shall:	Full	The plan submitted the 2012 QAPI Work Plan for review, which includes goals and objectives of the program. The Work Plan indicates that the plan is reviewed by the Board of Directors (BOD). As per the QAPI Program Description, the BOD evaluates the QAPI Work Plan to confirm that program objectives are met and recommends adjustments as necessary. Submission of the QAPI Work Plan to DHH is not specifically noted in the QAPI Program Description, although the QAPI Work Plan for 2012 labeled PQ 121 is in place. Recommendation: The plan should include submission of the QAPI Work Plan to DHH in the QAPI Program Description or other policies.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	Substantial	The2012 and 2013 QAPI Work Plans reflect planning, decision making and broadly addresses interventions and assessment of results. The 2013 QAPI Work Plan does not include an evaluation of results similar to the evaluation in the 2012 QAPI Work Plan, which includes a comment/status column that indicates progress on activities and refers to results in the QAPI Program Evaluation. The plan indicated that status of activities was no longer included in the QAPI Work Plan in lieu of documentation of progress monthly in the PIT committee. Although the QAPI Program Evaluation and Care Management Effectiveness Measures reports include planning for activities based on an analysis of program results and barriers, these activities are not all evident in the QAPI Work Plans, given the lack of detail. For example, while monitoring utilization is included in the 2013 Work Plan, identified opportunities for improvement in inappropriate NICU and C-section utilization are not specifically noted in the Work Plan. Recommendations: The plan should ensure that activities identified as planned activities and priorities in the Program	MCO response: The Plan will review both the QAPI Program Description and the QI Work Plan to ensure that all elements and components listed in the program description are included on the QI Work Plan to ensure that all interventions and monitoring requirements are met through the on-going management of the QI work plan. IPRO response: No change in determination. QI Work Plan will be reviewed as part of next year's audit to ensure that all components in the program description are included and that all interventions and monitoring requirements are met.

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			Evaluation appear in the Work Plan. Work Plans should reflect interventions and assessments of results, so that updates to the Work Plan reflect the continuous improvement cycle that is evident in other documents such as the QAPI Program Evaluation.	
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	Full	The QAPI plan as reflected in the Work Plan and Program Description includes processes to evaluate the impact and effectiveness of the QAPI Program, including but not limited to the annual QAPI Program Evaluation.	
14.2.3.3	Include a description of the CCN staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	Full	The QAPI Program Description includes a description of staff assigned to the QAPI Program and their organization and responsibilities. Specific training requirements for key QI staff are included in the QAPI Program Description. Responsible staff for various QAPI activities is designated in the QAPI Work Plan.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program.	Substantial	The QAPI Program Description and QAPIC Committee Charter identify providers named to the QAPIC, and the plan has established a Provider Advisory Committee (PAC) that is described as meeting on an ad hoc basis. Although five provider members with specialties including family practice and pediatrics are identified as members in the QAPIC Committee Charter, it does not appear that these members regularly attend meeting as per meeting minutes. The plan provided meeting minutes for three PAC meetings, one of which was canceled. Topics discussed included EPSDT, pharmacy, coding, Patient Centered Medical Home, and provider complaint processes. The minutes of the initial PAC meeting 8/8/12 identify an objective to be obtaining feedback from network providers on the program. Recommendation: The plan should ensure active network provider feedback on the QAPI program.	MCO response: The Plan Medical Director will work closely with the members of the QAPIC Committee and the Provider Advisory Committee to increase participation and communication from its members. The providers will be encouraged to share their clinical knowledge and expertise as well as give feedback on the performance measures of the Plan. IPRO response: No change in determination. PAC meeting minutes will be reviewed as part of next year's audit to evaluate member participation.
14.2.4	QAPI Reporting Requirements:	Full	The QAPI Program Description describes annual	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 CCN shall submit QAPI reports annually to DHH which, at a minimum, shall include: Quality improvement (QI) activities; Recommended new and/or improved QI activities; and Evaluation of the impact and effectiveness of the QAPI program.		reporting to DHH including QAPI Program Description, QAPI Program Evaluation and QAPIC meeting minutes.	
14.3				
14.3.1	The CCN shall report clinical and administrative performance measure (PM) data on an annual basis, as specified by DHH and in accordance with the specifications of the CCN Quality Companion Guide.	Full	Reporting of clinical and administrative measures as specified in DHH and the Quality Companion Guide is included in the QAPI Program Description. The plan provided reports of administrative performance measures for review. The 2012 Annual Quality Assessment and Performance Improvement Program Evaluation (QAPI Program Evaluation) indicates that although the plan has not yet reported DHH specified clinical performance measures, they are preparing for reporting. The plan is monitoring HEDIS measures and educating staff and providers regarding required performance measures.	
14.3.1.1	The CCN is required to report on PMs listed in Appendix J which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consume Assessment of Healthcare Providers and Systems (CAHPS) measures, and/or other measures as determined by DHH.	Full	These requirements are documented in the QAPI Program Description. The plan provided administrative measures reports, and indicated that the CAHPS survey is currently in the field and other required measures will be reported in 2014.	
14.3.1.2	The CCN shall have processes in place to monitor and self-report all performance measures.	Full	Processes for monitoring data are included in the QAPI Program Description. The plan provided reports of administrative measures and tracking of clinical measures, as well as provider profiling reports.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.3.1.3	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	Full	Reporting requirements are documented in the QAPI Program Description, and clinical PM outcomes will be reported beginning in 2014.	
14.3.1.4	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	Full	The plan provided the PQ217 QAPI Early Warning System Performance Measure report, which provided evidence of submission of administrative performance measures.	
14.3.1.5	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Full	The plan has not yet reported clinical performance measures. The plan has begun to trend HEDIS measures and low birthweight/preterm rates and the care management effectiveness measures (baseline) as described above.	
14.3.2	Incentive Based Performance Measures	N/A	The plan has not yet reported Incentive Based measures, which are planned for reporting in 2014.	
14.3.2.1	Incentive Based (IB) measures are Level I measures that may affect PMPM payments and can be identified in Appendix J annotated with "$".	N/A	The plan has not yet reported Incentive Based measures, which are planned for reporting in 2014.	
14.3.2.2	Based on a CCN's Performance Measure outcomes for CYE 12/31/2013, a maximum of 2.5% (0.5% for each of 5 specific IB measures) of the total monthly capitation payments may be deducted effective October following the measurement CY if specified performance measures fall below DHH's established benchmarks for improvement.	N/A	The plan has not yet reported Incentive Based measures, which are planned for reporting in 2014.	
14.3.2.3	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	N/A	The plan has not yet reported Incentive Based measures, which are planned for reporting in 2014.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 will provide sixty (60) days notice of such change.			
14.3.3	Performance Reporting Measures	N/A		
14.3.3.1	All Administrative, Level I and Level II PMs are reporting measures. • Administrative measure reporting is required semiannually and upon DHH request. • 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. • 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. • 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. • Level I and Level II PM reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.	Full	The plan provided the PQ217 QAPI Early Warning System Performance Measure report, which provided evidence of submission of Administrative performance measures. The plan will begin Level I and II measure reporting, including Prevention Quality Indicator measures, in 2014.	
14.3.3.2	DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.	N/A		
14.3.4	Performance Measure Goals	N/A		
14.3.4.1	The Department will establish	N/A		

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	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.			
14.3.4.2	Statewide goals will be set for 2015 Level II Performance Measure utilizing an average of all CCNs outcomes received in 2014 for the 2013 measurement year.	N/A		
14.3.5	Performance Measure Reporting	N/A		
14.3.5.1	The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Full	The plan demonstrated reports generated from LHC's Management Information Systems (MIS), which is described in the QAPI Program Description and includes clinical claims/encounters, member services, medical management, financial and provider information. The plan provided reports documenting monitoring of HEDIS measures, utilization, PCP profiles, EPSDT visits, call statistics, and care management data.	
14.3.5.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.	Full	The plan demonstrated reports that can be modified from claims and encounter data as well as complaints, grievance, appeals, care management data systems.	
14.3.5.3	The CCN shall have processes in place to monitor and self-report performance measures as specified in §14.3.3 Reporting Measures.	Full	The plan has processes in place to monitor and self report performance measures as described in the QAPI Program Description and evidenced by reports of Administrative measures and HEDIS tracking.	
14.3.5.4	The CCN shall provide individual PCP clinical quality profile reports as indicated in §8.22 PCP Utilization and Quality Reporting.	Full	The plan provided QAPI PCP profile reports (PQ072) documenting provider-specific specialist referrals, low and high level ER visits, hospital admissions, lab services, radiology services, medication and recipients with >12 office visits. Processes for provider profiling are outlined P/P CC.QI.22 Provider Profiling, and include utilization reporting as well as clinical performance	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
			measure profiling. The plan provided provider profiles for review, including utilization measures, EPSDT, cervical cancer screening. Provider profiling in the context of utilization is also addressed in P/P UM.01.03 Monitoring Utilization.	
14.3.6	Performance Measure Monitoring	N/A		
14.3.6.1	DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.	N/A		
14.3.6.2	During the course of the Contract, DHH or its designee will actively participate with the CCN to review the results of performance measures.	N/A		
14.3.6.3	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 provided requested documentation and files and made staff available for interview and assistance during the External Quality Review. Compliance with EQR and other reviews and audits are included in the QAPI Program Description.	
14.3.6.4	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	Full	The requirements for a Corrective Action Plan are detailed in the QAPI Program Description. Although the plan did not have a formal CAP required, the plan provided a proposed CAP shared with DHH that included the identified issue, planned actions and an	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	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 Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. DHH must prior approve the CAP and will monitor the CCN's progress in correcting the deficiencies.		incorporated timetable.	
14.3.7	Performance Measure Corrective Action Plan A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.	Full	This information is included in the QAPI Program Description, although a CAP for performance measurement was not required in the review period.	
14.3.7.1	The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the deficiencies identified by DHH.	Full	This information is included in the QAPI Program Description, although a CAP was not required in the review period.	
14.3.7.2	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 deficiencies identified by DHH.	N/A	This information is included in the QAPI Program Description, although a CAP was not required in the review period.	
14.3.7.3	Upon approval of the CAP, whether the initial CAP or the revised CAP, the CCN shall implement the CAP within the time frames specified by DHH.	N/A	This information is included in the QAPI Program Description, although a CAP was not required in the review period.	
14.3.7.4	DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	N/A		

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	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
14.3.8	Performance Improvement Projects	N/A		
14.3.8.1	The CCN shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures as specified in 42 CFR §438.240.	Full	Performance Improvement Projects are described in the QAPI Program Description and included in the QAPI Work Plans. The plan submitted status reports for tow DHH approved PIPs, and included reports of internal PIPS in the QAPI Program Evaluation which included initiatives to increase enrollment of pregnant members and high risk members in the Smart Start program, outreach to members with NICU babies, and a MemberConnections initiative to increase referrals to MemberConnections from PCPs for members with missed appointments.	
14.3.8.2	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 DD - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of Appendix DD. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.	Full	In the first contract year, the plan implemented two DHH approved PIPs, Reduction of Inappropriate ER Utilization and Increasing Cervical Cancer Screening, which are documented in the QAPI Program Evaluation and PIP status reports.	
14.3.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each PIP must involve the following: • Measurement of performance using objective quality indicators; • Implementation of system interventions to achieve improvement in quality;	Full	The two submitted Performance Improvement Projects are designed to decrease avoidable emergency department utilization and increase cervical cancer screening. As evidence in the plan-submitted PIP reports, the PIPs include objective quality indicators (HEDIS), system interventions that include notifications, outreach and incentives, tracking of results and analysis of results, and assessment of interventions through the life of the PIP. Specific opportunities for improvement communicated to the plan based on PIP validation included the incorporation of process measures to better track interventions, clarification of baseline and measurement timeframes and using alternative	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	• Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.		methods to measure improvements in ED utilization to facilitate interpretation of results.	
14.3.8.4	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: • An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers; • The study question; The study population; • The quantifiable measures to be used, including a goal or benchmark; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection cycle; • Data analysis cycle and plan; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Analysis and identification of opportunities for improvement; and • An explanation of all interventions to be taken.	Full	As noted above, the plan submitted a detailed PIP proposal for each of the two DHH approved PIPs and status reports that include a rationale for the PIP topic and its relevance, the study question, the population to be included, quantifiable performance measures and goals, methodology, data sources and collection procedures and timeframes, analysis, results, barriers, and an evaluation of interventions and actions to be taken. As noted above, process measures were recommended to facilitate evaluation of interventions.	
14.3.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts)	Substantial	The PIP reports include procedures for monitoring and tabular timelines and data presentations. The plan provided graphs illustrating ED visits by providers	MCO response: The Plan will review the PIP recommendations from the EQRO and incorporate them into the PIP reports where

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that appropriate health professionals analyze data; • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;		contacted and provider groups in the ED reduction pilot. The plan provided results for the ED and cervical cancer screening both system wide in the PIP reports and provider profiling for ED visits and cervical cancer screening. The PIPs target guideline-consistent cervical cancer screening and improving care coordination by decreasing reliance on ED utilization. The plan includes HEDIS measures reflective of cervical cancer screening guidelines and ED utilization for those members with frequent visits. System interventions include provider and member interventions, including case management, home visits, incentives and outreach. The plan provided PIP status reports which include an evaluation of the effectiveness of interventions. Opportunities for improvement generated by the validation of PIPs conducted by the EQRO included evaluating the effectiveness of interventions using process measures and facilitating the interpretation of results of the ED utilization PIP by calculating additional measures. Additional measurement for the ED PIP will allow for sufficient information to plan and initiate activities to increase or sustain improvement, as will process measures. The ED PIP is focused on members who are frequent utilizers of the ED, and all members are included in the cervical cancer screening PIP. PIP rationales establish the relevance of these PIPs to the plan's population. The QAPIC, which is a multidisciplinary committee, helps identify the study question, indicators and the QAPIC or subcommittees develop interventions. QAPIC minutes reflect discussion of PIPs. Qualifications of personnel responsible for analysis of data as outlined in the QAPI Program Description include clinical background; resources available for data analysis are also included in the QAPI Program Description. Objectives and quantifiable measures with goals are included for reach PIP. The QAPI Program Description and PIP reports include processes to ensure data	appropriate. IPRO response: No change in determination. PIP reports will be reviewed as part of next year's audit.

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	• Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.		reliability and consistency with statistical principles, and systems for tracking improvements. Recommendation: The plan should incorporate EQRO recommendation to include process measures for PIPs and to calculate additional measures for the ED PIP to allow interpretation of results that may be impacted by regression to the mean.	
14.3.8.6	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.	Full	The plan submitted PIP reports as required on two topics specified by DHH.	
14.3.8.7	If CMS specifies Performance Improvement Projects, the CCN will participate and this will count toward the state-approved PIPs.	N/A		
14.3.8.8	Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.	Full	The timelines for each PIP allow for completion in a timeline appropriate for annual evaluation of the success of the projects.	
14.3.9	PIP Reporting Requirements	N/A		
14.3.9.1	The CCN shall submit PIP outcomes annually to DHH.	Full	The plan submitted first year PIP status reports with results to date as required.	
14.3.9.2	Reporting specifications are detailed in the Quality Companion	N/A		

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	Guide.			
14.3.9.3	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		
14.4	**Member Satisfaction Surveys**			
14.4.1	The CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.	Full	The plan's first CAHPS survey is underway as of September 2013. The survey is currently in the field and slated to be completed in November 2013 as per the Work Plan, CCN CAHPS update and onsite staff.	
14.4.2	The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.	Full	The plan's CAHPS survey is being conducted by the Meyer's Group, an NCQA certified CAHPS vendor.	
14.4.2.1	The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.	Full	The CAHPS survey that is underway includes the Adult and Children with Chronic Conditions module survey.	
14.4.3	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	N/A	As the survey is still underway, results have not yet been reported to the State.	
14.4.4	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.	N/A	Reporting of results by GSA was not required of MCOs.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.4.5	The surveys shall provide valid and reliable data for results in the specific CCN GSA.	N/A	Reporting of results by GSA was not required of MCOs.	
14.4.6	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	N/A		
14.4.7	The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include:	Full	The plan is conducting the most current CAHPS Health Plan survey 5.0.	
14.4.7.1	Getting Needed Care	Full	This element is included in the CAHPS methodology.	
14.4.7.2	Getting Care Quickly	Full	This element is included in the CAHPS methodology.	
14.4.7.3	How Well Doctors Communicate	Full	This element is included in the CAHPS methodology.	
14.4.7.4	Health Plan Customer Service	Full	This element is included in the CAHPS methodology.	
14.4.7.5	Global Ratings	Full	This element is included in the CAHPS methodology.	
14.4.8	Member Satisfaction Survey Reports are due 120 days after the end of the plan year.	N/A	The plan is to submit the report in November 2013 as approved by DHH.	
14.5	**Provider Satisfaction Surveys**			
14.5.1	The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.	Substantial	The plan conducted an annual provider survey in 2012. The 2012 Provider Satisfaction Survey Report provided includes the survey instrument, which assesses satisfaction with enrollment, communication, education, claims and utilization management. There are no items relevant to the provider complaint process or support toward Patient Centered Medical Home implementation. Onsite staff indicated during interview and follow-up that the complaint process and medical home initiatives were too new to include in the survey, and would begin in 2013.	MCO response: By the time of the audit the 2013 Provider Satisfaction Survey was already printed and in the Providers' hands. We have requested that these 2 items be included in the 2014 survey In addition, by the end of the year, we will send a supplemental questionnaire that will include these 2 items to providers who received the 2013 Provider Satisfaction Survey.

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 ensure that DHH required items are included in annual provider surveys.	IPRO response: No change in determination. The annual provider survey process will be reviewed as part of next year's audit.
14.5.1.1	The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	Full	The Provider Satisfaction survey tool and methodology was submitted to DHH as per onsite staff. The Work Plan indicates reporting annually, although not explicitly noting submission of the survey tool and methodology to DHH.	
14.5.2	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 120 days after the end of the plan year.	Full	The plan submitted the annual Provider Satisfaction Survey Report with a summary of methods, findings and analysis comparing plan results to benchmarks.	
14.6	**DHH Oversight of Quality**			
14.6.1	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.	N/A		
14.6.2	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 automatic assignments.	N/A	The plan had no formal CAPS required in the review period. The plan provided a copy of CAP correspondence from July 2012 regarding concurrent review turnaround time; there was no associated formal CAP. The plan responded with a proposed corrective action plan within 13 days; the proposed plan included an explanation of the problem and detailed action plan with timeline.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.6.3	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.	N/A		
14.6.4	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.	N/A		
14.6.5	The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.	Full	LHC has cooperated and actively participated in the monitoring process.	
14.7	**External Independent Review**			
14.7.1	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 all information requested by the EQRO.	
14.7.2	The CCN shall cooperate with the EQRO during the review (including medical records review), which will be done at least one (1) time per year.	Full	The plan cooperated with the EQRO by providing documents and files and making staff available for interviews and assistance during the annual review.	
14.7.3	If the EQRO indicates that the quality of care is not within acceptable limits set forth in the	N/A	There has been no determination by the EQRO that quality of care is not within acceptable limits as in the contract.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	Contract, DHH may sanction the CCN in accordance with the provisions of § 20 of the Contract 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.			
14.7.4	A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the CCN's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQRO.	N/A	The QAPI Program Description indicates that the plan will work collaboratively with the State and EQRO to assess and implement interventions for improvement based on EQR findings.	
14.8	**Health Plan Accreditation**			
14.8.1	The CCN must attain health plan accreditation by NCQA or URAC. If the CCN is not currently accredited by NCQA or URAC, the CCN must attain accreditation by meeting NCQA or URAC's accreditation standards.	Full	The plan is currently preparing for NCQA accreditation as per the QAPI Program Evaluation, and is planning a mock survey through Centene. As per the QAPI Work Plan and a status update on NCQA accreditation provided by the plan, LHC submitted their application for accreditation in the summer of 2013, a standards survey is scheduled for 2014 and HEDIS/CAHPS will be added to accreditation in 2015.	
14.8.2	The CCN's application for accreditation must be submitted at the earliest point allowed by the organization. The CCN must provide DHH with a copy of all correspondence with NCQA or URAC regarding the application process and the accreditation requirements.	Full	The plan submitted its application for NCQA accreditation in summer 2013.	
14.8.3	Achievement of provisional accreditation status shall require a	N/A	The NCQA accreditation process is still underway.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA or URAC accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.			
14.9	**Credentialing and Re-credentialing of Providers and Clinical Staff**			
14.9.1	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.	Full	The plan's credentialing and recredentialing program is described in CC Cred.01 Credentialing Program Description. The Program covers licensed individual practitioners and organizational providers, and is consistent with State and NCQA guidelines by policy. Ten PCP and ten specialist credentialing files were reviewed and all elements were compliant for all files.	
14.9.1.1	The CCN shall use the state's standardized credentialing form (see Appendix F – Louisiana Standardized Credentialing Application Form).	Full	The Credentialing Program Description indicates that providers must complete the standard state application or data collection form, and Attachment C to the Program Description, Louisiana Health Care Connections Unique Credentialing Requirements indicates that Louisiana Healthcare Connections will accept and utilize the Louisiana Standardized Credentialing Application for the credentialing application.	
14.9.1.2	An independent relationship exists when the CCN selects and directs it members to see a specific provider or group of providers.	N/A		
14.9.1.3	These procedures shall be	Full	Appendix C of CC Cred.01 includes this requirement.	

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	submitted as part of the Proposal, when a change is made, and annually thereafter.			
14.9.2	The process for periodic re-credentialing shall be implemented at least once every three (3) years.	Full	As per CC Cred.01, providers must be credentialed and/or recredentialed every three years.	
14.9.3	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 delegated entity.	Full	The plan is undergoing the NCQA accreditation process. P/P CC CRED .02 Oversight of Delegated Credentialing describes processes for monitoring of credentialing when delegated. The plan determines whether the delegate has the capability to perform credentialing according to NCQA/JCAHO and other external requirements before delegating. If credentialing is delegated, a document signed by both parties outlines expectations for credentialing. This policy has an Attachment C that specifies all delegated entities credential in accordance with DHH credentialing requirements and that DHH will have final approval. The plan provided an example of a Delegated Services Agreement (Cenpatico), which indicates that Cenpatico will comply with state processes.	
14.9.4	If the CCN has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	N/A	The plan is undergoing the NCQA health plan accreditation process.	
14.9.5	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	P/P LA.CONT.02 outlines guidelines for selection, recruitment and maintenance of providers in the network. Indicates all providers must meet Louisiana credentialing requirements. P/P LA.PRVR.23 outlines procedures to ensure that all provider terminations are implemented accurately and timely so that contractual obligations are not compromised. This policy is Louisiana specific. P/P LA.CRED.13 indicates that the plan will monitor for consistency with community standards for board certification.	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
14.9.6	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.	Substantial	P/P CC.CRED.10 Practitioner Disciplinary Action and Reporting outlines procedures for reporting actions taken (suspension or termination due to competence or professional conduct) against providers for quality reasons. Reporting is also covered in P/P CRED .01 Credentialing Program Description, P/P CC.QI.18, Quality of Care Investigations and P/P CRED 10.01 Practitioner Appeal Hearing Process. Appendix C of P/P CC CRED.01 includes the requirement that changes to the Credentialing Program and supporting policies will be submitted for approval, relevant supporting policies are not identified. Individual policies relevant to reporting quality concerns do not explicitly note the required approval for changes. Recommendation: The plan should identify the required approval of changes in individual supporting credentialing policies or identify to which individual supporting credentialing policies this requirement applies in the Credentialing Program Description.	MCO response: Two specific P/Ps fall within the scope of this contract requirement: (1) P/P CC.CRED.10 Practitioner Disciplinary Action and Reporting, and (2) P/P CRED .01 Credentialing Program Description. The former is the primary procedural document describing Centene's mechanisms for reporting while the latter addresses these mechanisms at a summary level. The other P/Ps referenced - P/P CC.QI.18, Quality of Care Investigations and P/P CRED 10.01 Practitioner Appeal Hearing Process – merely refer readers to P/P CC.CRED.10, and do not themselves describe the mechanisms for reporting; thus, we believe these P/Ps should be considered out of scope of this contract requirement. Based on the above, Centene proposes to take the following actions: • P/P CC.CRED.10 Practitioner Disciplinary Action and Reporting – an attachment will be added to address unique requirements for Louisiana Healthcare Connections Plan articulating that policy/procedure changes associated with mechanisms for reporting of quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s) will be submitted to DHH for review and approval. • P/P CRED .01 Credentialing Program Description – attachment C will be modified to articulate that policy/procedure changes associated with mechanisms for reporting of quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s) will be submitted to DHH for review and approval. P/P CRED .01 Credentialing Program Description – attachment C will be modified to remove the phrase "and all supporting Policies & Procedures." This phrase will no longer be relevant as the specific P/Ps in scope

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State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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 this contractual requirement have been identified IPRO response: No change in determination. Updated policies, including the attachments; and the Program Description will be reviewed as part of next year's audit. Appendix C of P/P CC CRED.01 includes the requirement that changes will be submitted for approval. This appendix will not be needed to document evidence of this requirement if P/P CC.CRED.10 will be modified.
14.9.7	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 from the date the Contract is signed and at the time of any change.	Substantial	P/P CC.CRED.10.01 Practitioner Appeal Hearing Process gives opportunity for appeal if credentialing committee recommends suspension, revocation termination from provider network for reasons of competence or professional conduct. Appendix C of P/P CC.CRED.01 notes required approval of changes for all supporting credentialing policies, though these policies are not identified. This language is not included in P/P CC.CRED.10.01. Recommendation: The plan should identify the required approval of changes in individual supporting credentialing policies or identify to which individual supporting credentialing policies this requirement applies in the Credentialing Program Description.	MCO response: Based on this finding, Centene proposes to take the following actions: • P/P CC.CRED.10.01 Practitioner Appeal Hearing Process – an attachment will be added to address unique requirements for Louisiana Healthcare Connections Plan articulating that the provider dispute and appeal process for sanctions, suspensions, and terminations imposed against network provider/contractor(s) will be submitted to DHH for review and approval. • P/P CRED .01 Credentialing Program Description – as stated above, attachment C will be modified to remove the phrase "and all supporting Policies & Procedures." This phrase will no longer be relevant as the specific P/Ps in scope of this contractual requirement have been identified. IPRO response: No change in determination. Updated policies, including the attachments; and the Program Description will be reviewed as part of next year's audit.
14.10	**Member Advisory Council**			
14.10.1	The CCN shall establish a Member	Full	The Member Advisory Council is described in P/P	

Quality Management (QM)				
State Contract Requirements [Federal Regulation: 438.214, 438.240)	**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**
	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.		MBRS.05 Member Advisory Council (MAC). The Council's purpose is to facilitate obtaining the member's perspective on quality of care and services and recommendations for improvement.	
14.10.2	The Council is to be chaired by the CCN's Administrator/CEO/COO or designee and will meet at least quarterly.	Substantial	The Director of Member Services chairs the MAC as designated by the CEO. As per the QAPI Program description, the MAC meets at least quarterly, and the plan provided minutes for MAC meetings for quarters 3 and 4 of 2012 and quarter 1 and 2 of 2013. The MAC minutes submitted for quarter 3 2012 actually indicate that the MAC did not meet quarter 3 2012. It should be noted that P/P MBRS .05 indicates that the MAC will meet semiannually, although the QAPIC notes the MAC will meet quarterly. Recommendation: The plan should ensure that the MAC meets quarterly and documents consistently document the quarterly meeting requirement.	MCO response: Three MAC meetings have been documented and reported to DHH in 2013 with the fourth scheduled for November. Both the Member handbook and MBRS.05 will be updated to state the quarterly requirement. IPRO response: No change in determination. Updated handbook and policy will be reviewed as part of next year's audit. MAC meeting minutes will also be reviewed.
14.10.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Full	As per P/P MBRS .05, at least 50% of membership is comprised of parents, members, foster parents, guardians, member advocacy group representatives. Onsite staff described active efforts to solicit participation in various regions of the State. Meeting minutes reveal robust attendance by multiple members.	
14.10.4	The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Full	P/P MBRS .05 indicates that members will be provided orientation and training to understand their responsibilities. The plan provided minutes for each meeting conducted that reflect an opening orientation for members that outlines the purpose of the committee and expectations. This overview was	

Quality Management (QM)				
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			described by onsite staff.	
14.10.5	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 is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the Contract and annually thereafter by December 15th.	Full	The plan's P/P MBRS .05 is the Member Advisory Council plan and outlines a schedule of meetings (semiannually as noted above), and the plan notes the purpose of the MAC is to obtain members' perspectives to improve quality of care and services. Annual submission to DHH within 30 days of contract and annually by December 15 is included in the plan.	
14.10.6	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.	Full	As per P/P MBRS .05 DHH is copied on all correspondence to the MAC and minutes and agenda once approved will be posted to the plan's website. The plan provided minutes and agenda for review.	

Reporting				
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**
18.0	**Reporting**			
18.0	The CCN shall comply with all the reporting requirements established by this Contract. As per 42 CFR §438.242(a)(b)(1)(2) and (3), the CCN shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid eligibility. The CCN shall collect data on member and provider characteristics and on services furnished to members. The CCN shall create reports or files (known as Deliverables) using the electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the formats must be approved by DHH prior to implementation. The CCN shall provide DHH with a sample of all reports within forty-five (45) calendar days following the date the Contract is signed. In the event that there are no instances to report, the CCN shall submit a report so stating. As required by 42 CFR §438.604(a) and (b), and 42 CFR §438.606, the CCN shall certify all submitted data, documents and reports. The data that must be certified include, but	Full	LHC includes reporting requirements in policies related to individual activities, such as LA.QI.11.01 Grievance Process. Reports submitted to DHH were provided in the relevant review areas during the compliance review. Sample attestations were provided.	

Reporting				
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**
	are not limited to, enrollment information, financial reports, encounter data, and other information as specified within the Contract and this 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. The data shall be certified by one of the following: •CCN's Chief Executive Officer (CEO); •CCN's Chief Financial Officer (CFO); or •An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.			