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	Addressed in Medical Behavioral Health Collaboration, Provider Handbook and Member Handbook.	
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 Provider Handbook 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**
	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	Substantial	The Medical Behavioral Health Collaboration, Provider Handbook and Member Handbook do not explicitly address that medical services to be covered by the plan include Acute Medical Detoxification which provide the following: 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. Recommendation: The medical services covered by the plan should add the required elements of Acute Medical Detoxification.	

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 Emergency Room Services Policy and Procedure and Member Handbook.	
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 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 Emergency Room Services Policy and Procedure.	

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 Emergency Room Services Policy and Procedure.	
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 Emergency Room Services Policy and Procedure.	
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 Emergency Room Services Policy and Procedure.	
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 concerning discharge or transfer	Substantial	The Emergency Room Services Policy and Procedure did not explicitly address the process if there is a disagreement between a hospital or other treating facility and a plan concerning whether the member is stable enough for discharge or transfer from the emergency room, that the judgment of the attending emergency physician at the hospital or other treating facility prevails and is binding on the plan. Recommendation: The Emergency Room Services Policy and Procedure should be revised to include this requirement.	

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**
	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 Emergency Room Services Policy and Procedure.	
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 Member Handbook and ER Utilization PIP (Quality Improvement Form).	
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	Addressed in ER Utilization PIP (Quality Improvement Form).	
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.	Substantial	The Member Handbook did not explicitly address that 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. Recommendation: The Member Handbook should be revised to include this requirement.	
6.7.2	Post Stabilization Services	N/A		
6.7.2.1	The CCN is financially responsible	Full	Addressed in Emergency Room Services Policy and	

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**
	for post-stabilization care services obtained within or outside the CCN that are:		Procedure.	
6.7.2.1.1	Pre-approved by a network provider or other CCN representative; or	Full	Addressed in Emergency Room Services Policy and Procedure.	
6.7.2.1.2	Not preapproved by a network provider or other CCN representative, but:	Full	Addressed in Emergency Room Services Policy and Procedure.	
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 Emergency Room Services Policy and Procedure.	
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.	Substantial	Emergency Room Services Policy and Procedure did not address post-stabilization care services that the plan is financially responsible for if the plan's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available. Recommendation: The Emergency Room Services Policy and Procedure should be revised to include this requirement.	
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		

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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;	Non-Compliance	Emergency Room Services Policy and Procedure does not address this requirement. Recommendation**:** The Emergency Room Services Policy and Procedure should be revised to include this requirement.	MCO response: Updated P&P UM 905L to include 6.7.2.1.3.1. (Attached.) IPRO response: No change in determination, but policy change is noted and will be reviewed as part of next year's audit.
6.7.2.1.3.2	A network physician assumes responsibility for the member's care through transfer;	Non-Compliance	Emergency Room Services Policy and Procedure does not address this requirement. Recommendation**:** The Emergency Room Services Policy and Procedure should be revised to include this requirement.	MCO response: Updated P&P UM 905L to include 6.7.2.1.3.2. IPRO response: No change in determination, but policy change is noted and will be reviewed as part of next year's audit.
6.7.2.1.3.3	A representative of the CCN and the treating physician reach an agreement concerning the member's care; or	Non-Compliance	Emergency Room Services Policy and Procedure does not address this requirement. Recommendation**:** The Emergency Room Services Policy and Procedure should be revised to include this requirement.	MCO response: Updated P&P UM 905L to include 6.7.2.1.3.3. IPRO response: No change in determination but policy change is noted and will be reviewed as part of next year's audit.
6.7.2.1.3.4	The member is discharged.	Non-Compliance	Emergency Room Services Policy and Procedure does not address this requirement. Recommendation**:** The Emergency Room Services Policy and Procedure should be revised to include this requirement.	MCO response: Updated P&P UM 905L to include 6.7.2.1.3.4. IPRO response: No change in determination but policy change is noted and will be reviewed as part of next year's audit.
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 ICM Program Description.	
6.16.2	The CCN shall identify members	Full	Addressed in Case Management Reports,	

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**
	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 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.		039LAC2012Q4, ICM Program Description, and Referral of Members to Case Management.	
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 Referral of Members to Case Management.	
6.16.3.2	The CCN PCPs shall identify to the CCN those members who meet SHCN criteria.	Full	Addressed in Referral of Members to Case Management.	
6.16.3.3	Members may self identify to either the Enrollment Broker or the CCN that they have special health care	Full	Addressed in Referral of Members to Case Management.	

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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**
	needs. The Enrollment Broker will provide notification to the CCN of members who indicate they have special health care needs.			
6.16.4	Individualized Treatment Plans	N/A		
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 Complex Care Management Standards of Practice. Case Management File Review: 18 of 18 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning.	
6.16.4.2	Approved by the CCN in a timely manner if required by the CCN; and	Full	Addressed in Complex Care Management Standards of Practice.	
6.16.4.3	In compliance with applicable QA and UM standards.	Full	Addressed in Complex Care Management Standards of Practice.	
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 ICM Program Description and Member Handbook.	
6.24.2	The CCN shall be responsible for ensuring:	N/A		

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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**
6.24.2.1	Member's health care needs and services/care are planned and coordinated through the CCN PCP;	Full	Addressed in Provider Handbook.	
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 availability of information, referral, and treatment for emergency medical conditions; and	Full	Addressed in Provider Handbook and Member Handbook.	
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 Complex Care Management Standards of Practice.	
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	Full	Addressed in Complex Care Management Standards of Practice, Provider Handbook, Member Handbook and Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	

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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**
	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.			
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 Member and Provider Handbook.	
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 Prior Authorization for Non-Participating/Out-of-Network Practitioners and Providers.	
6.25.2.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Full	With DHH approval, LaCare no longer requires members to receive a written PCP referral to see a specialist.	
6.25.2.4	Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical	Full	With DHH approval, LaCare no longer requires members to receive a written PCP referral to see a specialist.	

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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**
	care over a prolonged period of time;			
6.25.2.5	Process for member referral for case management;	Full	Addressed in Referral of Members to Case Management.	
6.25.2.6	Process for member referral for chronic care management;	Full	Addressed in Referral of Members to Case Management.	
6.25.2.7	Policy that prohibits providers from making referrals for designated health services to healthcare entities with which the provider or a member of the provider's family has a financial relationship.	Full	Addressed in Provider Handbook.	
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 Provider Handbook.	
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 Provider Handbook.	
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 Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	
6.25.2.11	DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems.	N/A	With DHH approval, LaCare no longer requires members to receive a written PCP referral to see a specialist.	

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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	**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 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.	Full	Addressed in Coordination with other Healthcare and non-Healthcare Services Policy and Procedure, Care Transition Policy and Procedure and Care Transition: Plan or Provider Change Policy and Procedure.	
6.26.2	The CCN shall be responsible for the coordination and continuity of care of healthcare services for all members.	Full	Addressed in Care Transition: Plan or Provider Change Policy and Procedure.	
6.26.3	The CCN shall implement DHH	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**
	approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:			
6.26.3.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Full	Addressed in Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	
6.26.3.2	Coordinate care between PCPs and specialists;	Full	Addressed in Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	
6.26.3.3	Coordinate care for out-of-network services, including specialty care services;	Full	Addressed in Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	
6.26.3.4	Coordinate CCN provided services with services the member may receive from other health care providers;	Full	Addressed in Coordination with other Healthcare and non-Healthcare Services Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition Policy and Procedure.	
6.26.3.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Full	Addressed in Care Transition Policy and Procedure.	
6.26.3.8	Coordinate hospital and/or	Full	Addressed in Care Transition Policy and Procedure.	

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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**
	institutional discharge planning that includes post-discharge care as appropriate;			
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 ICM Program Description.	
6.26.3.10	Document authorized referrals in its utilization management system;	Full	Addressed in Prior Authorization for Non-Participating/Out-of-Network Practitioners and Providers.	
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 Provider Termination Process and Care Transition: Plan or Provider Change Policy and Procedure.	
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 Medical Behavioral Health Collaboration and Provider Handbook.	
6.30.2	In order to ensure continuity and coordination of care for members who appear to need specialized behavioral health services or who	Full	Addressed in Medical Behavioral Health Collaboration and Provider 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**
	may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system or other managed care arrangement responsible for specialized behavioral health services (as applicable) for services.			
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 Medical Behavioral Health Collaboration.	
6.30.4	The CCN shall comply with all post stabilization care service requirements.	Full	Addressed in Medical Behavioral Health Collaboration.	
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 Medical Behavioral Health Collaboration.	
6.30.6	The network shall provide procedures and criteria for making referrals and coordinating care with	Full	Addressed in Medical Behavioral Health Collaboration.	

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**
	behavioral health providers and agencies that will promote continuity, as well as, cost-effectiveness of care.			
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.	Full	Addressed in Medical Behavioral Health Collaboration.	
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 Case Manager Interview Manual for Behavior Health Assessment.	
6.32	**Care Transition**			
6.32.1	Provide active assistance to members when transitioning to another provider (CCN, or Medicaid FFS).	Full	Addressed in Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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	Full	Addressed in Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	

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**
	PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.			
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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	Full	Addressed in Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	

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**
	within ten (10) business days of the receiving CCN's PCP's request.			
6.32.5	Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.	Full	Addressed in Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
6.32.8.3	Members who have conditions	Full	Addressed in Care Transition: Plan or Provider Change	

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**
	requiring ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth;		Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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 Care Transition: Plan or Provider Change Policy and Procedure and Care Transition Policy and Procedure.	
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	Full	Addressed in Addressed in ICM Program Description with Signatures, and ICM Program Evaluation 2013 and Development of Policy and Procedures.	

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**
	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 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 Complex Care Management Standards of Practice and Case Management/Care Coordination Blended Model for Disease Management.	
6.33.2.2	Assessment of a member's risk factors;	Full	Addressed in Complex Care Management Standards of Practice and Case Management/Care Coordination Blended Model for Disease Management. Case Management File Review: 18 of 18 case management files reviewed contained documentation of an assessment of the member's risk factors.	
6.33.2.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Non-Compliance (Based on a review of Policy 156.102, determination is changed to Substantial)	Not addressed in documents provided.	MCO response: This requirement is met through CM policy 156.102 (ICM Standards of Practice) submitted. Page 2 paragraph 3 states: "Care Plan Interventions include education based on the Member's general health and their specific clinical condition; promotion of medication adherence, routine Medical Home/PCP/Specialist (SPC) visits, and lifestyle modification; ….."

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**
				IPRO response: Based on a review of language in policy 156.102, determination is changed to "Substantial." It is recommended that the plan more explicitly address PCMH education for members including educating them regarding PCMH's in their area
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;	Substantial	Addressed in Complex Care Management Standards of Practice and ICM Program Description. Case Management File Review: 17 of 18 case management files reviewed contained an individualized treatment plan based on the needs assessment. One file did not contain a treatment plan related to the member's depression and anxiety. 18 of 18 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning. 18 of 18 case management files reviewed contained an individualized treatment plan based on documentation of short and long term treatment objectives.	
6.33.2.5	Referrals and assistance to ensure timely access to providers;	Full	Addressed in Complex Care Management Standards of Practice. Case Management File Review: 18 of 18 case management files reviewed contained documentation of care coordination that actively links the member to providers and medical services.	
6.33.2.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Full	Addressed in Complex Care Management Standards of Practice. Case Management File Review: 18 of 18 case management files reviewed contained documentation of care coordination that actively links	

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**
			the member to providers, medical services, residential, social, community and other support services where needed.	
6.33.2.7	Monitoring;	Substantial	Addressed in Complex Care Management Standards of Practice. Case Management File Review: 17 of 18 case management files reviewed contained documentation of monitoring of outcomes. 16 of 18 case management files reviewed contained documentation of revision of the treatment plan as necessary.	
6.33.2.8	Continuity of care; and	Full	Addressed in Complex Care Management Standards of Practice. Case Management File Review: 18 of 18 case management files reviewed contained documentation of care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed. 16 of 16 case management files reviewed contained documentation of coordination with the Chronic Care Management Program, as applicable.	
6.33.2.9	Follow-up and documentation.	Substantial	Addressed in Complex Care Management Standards of Practice. Case Management File Review: 17 of 18 case management files reviewed contained documentation of monitoring of outcomes. 16 of 18 case management files reviewed contained documentation of revision of the treatment plan as necessary.	
6.34	**Case Management (CM) Policies and Procedures**			

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**
6.34.0	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 Development of Policy and Procedures.	
6.34.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Full	Addressed in Complex Care Management Standards of Practice.	
6.34.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Full	Addressed in Referral of Members to Case Management.	
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 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;	Full	Addressed in Complex Care Management Standards of Practice.	
6.34.4	A strategy to ensure that all members and/or authorized family	Full	Addressed in Complex Care Management Standards of Practice.	

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**
	members or guardians are involved in treatment care planning;		Case Management File Review: 18 of 18 case management files reviewed contained documentation that the member/authorized family member/guardian were involved in treatment care planning.	
6.34.5	Procedures and criteria for making referrals to specialists and subspecialists;	Full	Addressed in Complex Care Management Standards of Practice.	
6.34.6	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs; and	Full	Addressed in Complex Care Management Standards of Practice.	
6.34.7	Coordinate Case Management activities for members also receiving services through the CCN's Chronic Care Management Program.	Full	Addressed in ICM Program Description. Case Management File Review: 16 of 16 case management files reviewed contained documentation of coordination with the chronic care management program, as applicable.	
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	Addressed in Case Management Reports.	
6.35.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	Full	Addressed in Case Management Reports.	
6.35.2	Number of members with special healthcare needs identified by the	Full	Addressed in Case Management Reports.	

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**
	member's PCP;			
6.35.3	Number of members with assessments;	Full	Addressed in Case Management Reports.	
6.35.4	Number of treatment plans completed, and	Full	Addressed in Case Management Reports.	
6.35.5	Number of members with assessments resulting in a referral for Case Management.	Full	Addressed in Case Management Reports.	
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 Case Management/Care Coordination Blended Model for Disease Management and asthma, cardiovascular, COPD, Diabetes and Sickle cell blueprints.	
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; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to DHH.	Full	Addressed in the asthma, cardiovascular, COPD, Diabetes and Sickle cell blueprints.	
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	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**
	develop and implement policies and procedures that:			
6.36.3.1	Include the definition of the target population;	Full	Addressed in the ICM Program Description.	
6.36.3.2	Include member identification strategies;	Full	Addressed in the ICM Program Description.	
6.36.3.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Full	Addressed in the Chronic Care Management Blue Prints and ICM Program Description.	
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 the Chronic Care Management Blue Prints and ICM Program Description.	
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 the Chronic Care Management Blue Prints and ICM Program Description.	
6.36.3.6	Include methods for informing and educating members and providers;	Full	Addressed in the Chronic Care Management Blue Prints and ICM Program Description.	
6.36.3.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in the Chronic Care Management Blue Prints, ICM Program Description and in Complex Care Management Standards of Practice.	
6.36.3.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in ICM Program Description and HEDIS rates.	
6.36.3.9	Address co-morbidities through a whole-person approach;	Full	Addressed in Complex Care Management Standards of Practice. Chronic Care management File Review:	

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**
			17 of 17 chronic care management files reviewed contained documentation of addressing co-morbidities.	
6.36.3.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	Substantial	Addressed in Case Management/Care Coordination Blended Model for Disease Management. Chronic Care Management File Review: 16 of 17 chronic care management files reviewed contained a treatment plan with interventions related to the member's chronic condition. One file did not contain a treatment plan, it was blank. 17 of 17 chronic care management files reviewed contained documentation of the member's risk stratification level. 17 of 17 chronic care management files reviewed contained documentation of empowering the member to effectively manage disease and prevent exacerbation and complications. 17 of 17 chronic care management files reviewed contained documentation of addressing co-morbidities. 16 of 16 chronic care management files reviewed contained documentation of coordination with the case management program, as applicable.	
6.36.3.11	Include Program Evaluation requirements.	Full	Addressed in Complex Care Management Standards of Practice.	
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 Complex Care Management Standards of Practice, DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
6.37.2	The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare	Full	Addressed in DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	

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**
	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:			
6.37.2.1	A brief history of the tool's development and historical and current uses;	Full	Addressed in DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
6.37.2.2	Medicaid data elements to be used for predictors and dependent measure(s);	Full	Addressed in DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
6.37.2.3	Assessments of data reliability and model validity;	Full	Addressed in DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
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 DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
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 DSTHS CareAnalyzer and 04 LAC 2013 Predictive Modeling Specs.	
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 CCMP Reports.	
6.38.2	The CCMP reports shall contain at a minimum:	N/A		
6.38.2.1	Total number of members;	Full	Addressed in CCMP Reports.	

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**
6.38.2.2	Number of members in each stratification level for each chronic condition; and	Full	Addressed in CCMP Reports.	
6.38.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	Full	Addressed in CCMP Reports.	
6.38.3	The CCN shall submit the following report annually:	N/A		
6.38.3.1	Program evaluation.	Full	Addressed in CCMP 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**
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement. The GeoAccess reports show that members have adequate access to providers of all specialties across all parishes, and where there are gaps in access, the plan is working to contract with providers to fill those gaps.	
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	Full	P/P NM 303 (Network Development, Management and Accessibility) meets 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**
	members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients within the same GSA who are not enrolled in the CCN Program. 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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
7.1.4	The proposed network shall be sufficient to provide core benefits and services within designated time and distance limits.	Full	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
7.1.5	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid	Full	P/P NM 303 (Network Development, Management and Accessibility) meets 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**
	members with disabilities.			
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 participate in the CCN, the CCN has met this requirement; the CCN shall maintain documentation detailing efforts made.	Full	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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	Full	P/P NM 303 (Network Development, Management and Accessibility) meets 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**
	specialists or for different practitioners in the same specialty.			
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 not participate in the CCN, the CCN shall maintain documentation detailing efforts that were made.	Full	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
7.1.12	If the CCN terminates a provider's contract for cause, the CCN shall provide immediate written notice to the provider.	Full	NM 301 (Provider Termination Process) meets 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**
	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.			
7.1.13	The CCN shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each CCN member who received his or her primary care from or was seen on a regular basis by the terminated provider.	Full	Sample letters provided. P/P NM 301 (Provider Termination Process) meets this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
7.1.15.2	Provide core services directly or enter into written agreements with	Full	Sample letters provided. P/P NM 301 (Provider Termination Process) meets 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**
	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.			
7.1.15.3	Not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/search.aspx and www.EPLS.gov and Health Integrity and Protection Data Bank at http://www.npdb-hipdb.hrsa.gov/index.jsp.	Full	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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	Requirement met through credentialing section of the Provider Handbook. Policy 210.001 (Credentialing and Recredentialing – Practitioners) meets this requirement.	
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,	Full	The sample PCP, Specialist and FQHC contracts meet 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**
	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 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	Plan meets this requirement through P/P 124.12.005L (Transportation for emergent and non-emergent care).	
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	NM 201: On an annual basis, the plan monitors the compliance of all participating PCP Offices against the established Accessibility Standards. The data collected to monitor for compliance include Appointment Access to Data Only, After-Hours Access Data Only, and Appointment Access and After-Hours Access Data. All non-compliant providers are notified of all categories requiring improvement. The non-compliant providers are given a timeline for submitting a corrective action to meet the performance standards. After Hours Research Report: The plan submitted this report to demonstrate that they monitor after-hours access. The plan also has a	MCO response: ACLA is currently developing methodology to perform an appointment accessibility survey in 2014. IPRO response: No change in determination, but survey process and findings 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**
			document called LaCare Provider Afterhours Corrective Action Steps which details the process for addressing provider after-hours access issues. During the interview, the plan explained that that they do not carry out a formal survey to monitor access and availability standards especially with regard to emergency, routine and urgent appointments. The plan currently monitors these standards via the Account Executives that go onsite and use a paper tool (Network Management Field Report) to determine compliance with appointment standards. The tools asks the provider – 1) Is the provider panel currently open? Y/N 2) If closed, is the provider interested in opening the panel? 3) Are same day appointments available daily? Y/N 4) Does the practice have a no show policy? 5) Does office have a system in place to remind patients of appointments? The tool is not sufficient to monitor access and availability standards and it would be difficult to abstract reportable/informative data for DHH reporting purposes. Recommend that the plan carry out a mystery shopper survey annually on a sample of the providers within their network, stratified by GSA, where the surveyor would try to obtain an appointment based on urgent, emergency and routine scenarios. After corrective action plans have been prepared and communicated with non-compliant providers, a resurvey of the non-compliant providers should be carried out to assess whether the providers have addressed their access issues.	

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**
7.1.15.8	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	P/P 124.12.005L (Transportation for emergent and non-emergent care) meets this requirement.	
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	P/P NM 303 states that the plan considers the cultural competency of providers in determining network capacity. P/P NM 201 (Provider Accessibility Standards and Compliance) states that PCPs must comply with all Cultural Competency standards. The Provider Handbook (Cultural Competency) states that "If a LaCare member requires or requests translation services because he/she is either non-English speaking, or of limited or low English proficiency, or if the member has some other sensory impairment, the health care provider has a responsibility to make arrangements to procure translation services for those members, and to facilitate the provision of health care services to such members."	
7.1.15.10	The CCN shall at least quarterly validate provider demographic data to ensure that current, accurate,	Full	P/P NM 303 meets 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**
	and clean data is on file for all contracted providers. Failure to do 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	Physician Office Standards and Requirements section of the Provider Handbook v4 meets this requirement.	
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	Physician Office Standards and Requirements section of the Provider Handbook v4 meets this requirement.	
7.2.2.1	Denying or not providing to a member any covered service or availability of a facility.	Full	Physician Office Standards and Requirements section of the Provider Handbook v4 meets this requirement.	
7.2.2.2	Providing to a member any covered service which is different, or is	Full	Physician Office Standards and Requirements section of the Provider Handbook v4 meets 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**
	provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.			
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	Physician Office Standards and Requirements section of the Provider Handbook v4 meets this requirement.	
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	P/P NM 303 meets this requirement.	
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	Full	P/P NM 201 Provider Accessibility Standards and Compliance Policy defines the annual process in which Provider offices are monitored for their compliance with the LaCare's Accessibility Standards. P/P NM 202 (Provider Geographical Access Policy)	

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**
	RFP. DHH will monitor the CCN's 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:		defines the process in which the plan annually measures and analyzes its performance against the geographic access standards for primary care practitioners, obstetrician-gynecologists, and required specialists. It states that LaCare monitors the geographic availability of the plan's network of participating providers to ensure that members have timely access to health care services as well compliance with the requirements of the Louisiana Department of Health and Hospitals (DHH) on an annual basis. The plan submitted a sample of quarterly network adequacy reports. The plan also submitted Geo Access reports of their provider network.	
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	The Provider Handbook (Physician Office Standards and Requirements) states "24 hour/ 7 days per week coverage must be available via the PCP for Urgent and Emergency Medical Condition care. An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage. For example, it is not acceptable to have a message on an answering machine that instructs the member to go to the emergency room for care without providing instructions on how to reach the PCP." The Member Handbook states that members can call their PCPs for medical problems 24 hours a day, 7 days a week. The plan has a Nurse Line (1-888-632-0009) which is available 24 hours a day, 7 days a week. P/P NM 201 (Provider Accessibility Standards and Compliance Policy) states "24 hour/ 7 days per week	

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**
			coverage must be available via the PCP for Urgent and Emergency Medical Condition care. An answering machine message that does not answer the call by 10 rings or provide instructions on how to reach the PCP does not constitute coverage. For example, it is not acceptable to have a message on an answering machine that instructs the member to go to the emergency room for care without providing instructions on how to reach the PCP." Also addressed in P/P NM 203 (Access Standards and Compliance Quarterly Audit Procedure).	
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 must be submitted in writing to DHH for approval.	Full	The Network Development Plan document shows an analysis of the plan's network with respect to travel times and/or distance requirements.	
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	The Network Development Plan document shows an analysis of the plan's network with respect to travel times and/or distance requirements. The report shows that the plan has identified that they have gaps in their network and have included corrective action plans for each.	
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	Full	The Network Development Plan document shows that the plan meets the maximum travel time and/or distance requirements to hospitals for rural and urban areas.	

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**
	request, in writing, an exception to this requirement.			
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 the Network Development Plan and geo access reports. The following gaps have been identified: a. Chiropractic- A gap is present in Region 7, Caddo and Desoto parishes; Network Management staff is contracting with Chiropractors identified in the greater Shreveport area. b. Endocrinology/Metabolism- A small gap is present in the Southwest portion of the state to include parts of Vernon, Beauregard, Calcasieu and Cameron parishes. LaCare Network Management staff is finalizing contracts with providers based in Lake Charles to fill this gap. c. Hemodialysis-A gap is present in the North Eastern portion of region 8. Network Management is finalizing a contract with Fresenius, which is expected to close this gap. d. Infectious Disease-A small gap is present in the far northeast portion of region 8. This is a true gap. e. Nuclear Medicine-A gap is present in the rural corridor of Cameron, Vernon, Grant, LaSalle, Catahoula, Caldwell, Madison, Tensas, Richland, Morehouse and East/West Carroll Parishes. Network Management staff is in the process of finalizing contracts with providers that will provide coverage to these areas. f. Orthopedics/Orthopedic Surgery-A gap is identified along the rural corridor; Network Management is finalizing contracts with providers who will facilitate access for members in these parishes. g. Pediatric Allergy-A gap is present along the rural corridor; Network Management is finalizing contracts with HCA-owned providers groups that will fill this gap. h. Podiatry-A gap is present in the far Northeastern portion of the state; primarily East/West Carroll	

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**
			parishes. Network Management has identified Vicksburg Mississippi providers who, once contracted will fill this gap. i. Rheumatology-A gap is present along the rural corridor. A contract is being finalized with HCA-owned provider groups, which will fill this gap. j. Cardiovascular Surgery-A gap is present along the rural corridor. A contract with HCA-owned provider group is in the process which will fill this identified gap. k. Colon/Rectal Surgery- A state wide gap has been identified. Network Management is identifying providers to close this gap. l. Neurological Surgery- A state wide gap has been identified. Network Management is identifying providers to close this gap. m. Pediatric Surgery-A gap is present in GSA C; Network Management is identifying providers to close this gap. n. Plastic Surgery-A gap is present in East/West Carroll parishes. This is a true gap. Providers are being identified in Vicksburg Mississippi area for contracting. o. Thoracic Surgery-A gap is referenced in lower Cameron parish. This is a true gap. Network Management is finalizing contracts with Beaumont Texas based providers who will provide coverage to this area, as well as, Calcasieu and Beauregard parishes.	
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	The Network Development Plan document shows that the plan meets the maximum travel time and/or distance requirements to Lab and Radiology Services for rural and urban areas.	

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	The plan meets this requirement through P/P NM 201 (Provider Accessibility Standards and Compliance Policy and Procedure) and NM 203 (Access Standards and Compliance Quarterly Audit Procedure).	
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.	Full	The plan meets this requirement through P/P NM 201 (Provider Accessibility Standards and Compliance Policy and Procedure) and NM 203 (Access Standards and Compliance Quarterly Audit Procedure). Both the Member Handbook and the Provider Handbook contain the access standards as well.	
7.5	**Timely Access**			
7.5	The CCN shall ensure that medically necessary services are available on	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	a timely basis, as follows:			
7.5.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergency services must be available at all times.	Full	Appointment Accessibility Standards section of the Member Handbook meets this requirement. Access Standards for PCPs section of the Provider Handbook meets this requirement. P/P NM 201 meets this requirement.	
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	Appointment Accessibility Standards section of the Member Handbook meets this requirement. Access Standards for PCPs section of the Provider Handbook meets this requirement. P/P NM 201 meets this requirement.	
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	Appointment Accessibility Standards section of the Member Handbook meets this requirement. Access Standards for PCPs section of the Provider Handbook meets this requirement. P/P NM 201 meets this requirement.	
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 (14) days; within the second trimester within seven (7) days; within their third trimester within	Full	Access Standards for PCPs section of the Provider Handbook meets this requirement. P/P NM 201 meets 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**
	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	Access Standards for PCPs section of the Provider Handbook meets this requirement. P/P NM 201 meets this requirement.	
7.5.6	Specialty care consultation within one (1) month of referral or as clinically indicated;	Substantial	Specialist Access & Appointment Standards section of the Provider Handbook meets this requirement. P/P NM 201 should also mention this standard for consistency.	
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	Substantial	P/P NM 201 meets this requirement. The Member and the Provider Handbook should also mention this standard for consistency.	
7.5.8	Follow-up visits in accordance with ER attending provider discharge instructions.	Full	P/P NM 201 meets this requirement.	
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	Full	Appointment Accessibility Standards section of the Member Handbook and Additional Requirements of PCPs section of the Provider Handbook both state that the waiting time for scheduled appointments must be no more than 45 minutes. The Provider Handbook meets this requirement. The plan has a toll-free 24/7 Nurse Call Line. P/P NM 201 (Access Standards and Compliance	

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 was scheduled. If a provider is delayed, patients shall 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.		Quarterly Audit Policy and Procedure) meets this requirement.	
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	P/P NM 203 (Access Standards and Compliance Quarterly Audit Procedure) shows that the plan has procedures in place to monitor access standards within its network and implement corrective action when necessary. P/P NM 201 (Access Standards and Compliance Quarterly Audit Policy and Procedure) states that "On an annual basis, LaCare monitors the compliance of all participating PCP Offices against the established Accessibility Standards. The data collected to monitor for compliance include Appointment Access to Data Only, After-Hours Access Data Only, and Appointment Access and After-Hours Access Data." The plan submitted the after-hours research report to demonstrate that it monitors after-hours coverage by its network providers. The results of the research show that after hours compliance is at 81%. The current method being used by the plan to monitor access and availability standards is not sufficient.	MCO response: ACLA is currently developing methodology to perform an appointment accessibility survey in 2014. IPRO response: No change in determination, but survey process and findings 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**
			Recommend that the plan carry out a mystery shopper survey annually on a sample of the providers within their network, stratified by GSA, where the surveyor would try to obtain an appointment based on urgent, emergency and routine scenarios. After corrective action plans have been communicated with non-compliant providers by the plans, a resurvey of the non-compliant providers could be carried out to determine if the providers have addressed their access issues.	
7.5.11	The CCN must use the results of appointment standards monitoring 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.	Minimal	The current method being used by the plan to monitor access and availability standards is not sufficient. The plan has a Nurse Line (1-888-632-0009) which is available 24 hours a day, 7 days a week.	MCO response: ACLA is currently developing methodology to perform an appointment accessibility survey in 2014. IPRO response: No change in determination, but survey process and findings 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	P/P NM 201 Access Standards and Compliance Quarterly Audit Policy and Procedure states "The PCP must have a "no show" follow-up policy. Two (2) notices of missed appointments and a follow-up telephone call should be made for any missed appointments and documented in the medical record. Should the PCP encounter members who habitually miss appointments, please contact our Rapid Response (RR) Team. Our RR Care Connectors will contact the member to counsel and educate them about the importance of keeping appointments." Specialist Access & Appointment Standards section of	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			the Provider Handbook states, "PCPs should be aware that we offer transportation assistance for our members and assistance getting to appointments can be gotten by calling our transportation vendor, MTM, at 888-913-0364. When the PCP encounters members who habitually miss appointments, please contact our Rapid Response Team. Our Rapid Response Care Connectors will contact the member to counsel and educate them about the importance of keeping appointments. LaCare will also conduct quarterly surveys to monitor the no-show rate." Also referenced in Additional Requirements of PCP.	
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 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.	Full	P/P NM 203 (Access Standards and Compliance Quarterly Audit Procedure) and P/P NM 201 (Access Standards and Compliance Quarterly Audit Policy and Procedure) both state that providers are educated by Network Management staff on an as needed basis, i.e. if they are found to be non-compliant with accessibility standards. The Provider Handbook contains appointment standards except for 7.5.7.	
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,	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement. Getting Care, Staying Healthy section of the Member Handbook explains the role of the PCP, which meets 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**
	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.		Physician Office Standards and Requirements section of the Provider Handbook explains the role of the PCP.	
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 provider.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.6.2.2	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the	Full	P/P NM 303 (Network Development Management Accessibility) meets 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**
	following unless approved by DHH: Nurse Practitioner 1 : up to 1,000			
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	Full	P/P NM 303 (Network Development Management Accessibility) meets 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**
	patients.			
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	NM 301 (Provider Termination Process) meets this requirement.	
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	Provider Handbook meets this requirement.	
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	Provider Handbook meets this requirement.	
7.7.2.1	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available; and	Full	Provider Handbook meets this requirement.	
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	Full	Provider Handbook meets 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**
	patients.			
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	Provider Handbook meets this requirement.	
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	Provider Handbook meets this requirement.	
7.7.2.2.3	Maintaining a medical record of all services rendered by the PCP and other referral providers; and	Full	Provider Handbook meets this requirement.	
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	Provider Handbook meets this requirement.	
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 of care.	Full	Provider Handbook meets this requirement.	
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	Provider Handbook meets this requirement.	
7.7.2.2.7	To ensure that in the process of	Full	Provider Handbook meets 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**
	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.			
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 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	Full	P/P NM 201 (Provider Accessibility Standards and Compliance Policy and Procedure) requires providers to have After-Hours Care by a PCP or a covering PCP available 24 hours 7 days a week. It further states that when the PCP uses an answering service or answering machine to intake calls after normal business hours, the call must be answered by ten (10) rings, and returned within 30 minutes. The following information must be included in the message: • Instructions for reaching the PCP • Instructions for obtaining emergency care.	

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**
	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	Provider Handbook meets this requirement. P/P NM 201 (Provider Accessibility Standards and Compliance Policy and Procedure) meets this requirement.	
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 shall ensure access to appropriate service settings for members needing medically high	Full	P/P NM 303 (Network Development Management Accessibility) meets 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**
	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	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that the members have adequate access to specialists.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that the members have adequate access to specialists.	
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 provider/member ratios are the minimum the CCN must provide.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that the members have adequate access to specialists.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	The 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.	Substantial	This contract language was not found in P/P NM 303 (Network Development Management Accessibility). GeoAccess reports show that the members have adequate access to Ancillary services, including home health services.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that the plan's members have access to hospitals except for 0.8% of the urban population and 0.2% of the rural population. The Network Dev Service Coverage document shows that the plan has met geo access requirements set by the DHH.	
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	Full	GeoAccess reports show that the plan's members have access to hospitals except for 0.8% of the urban population and 0.2% of the rural population. The Network Dev Service Coverage document showed that the plan has met geo access requirements set by the DHH.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the parish has such a hospital. 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	P/P NM 303 (Network Development Management Accessibility) meets this requirement. During the onsite, the Network Management Director explained that for "true gaps" in their provider network coverage, they do file for exceptions with the DHH or contract with out of state hospitals.	
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	During the onsite, the Network Management Director explained that for "true gaps" in their provider network coverage, they do file for exceptions with the DHH or contract with out of state hospitals.	
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	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement. The plan provided service contracts with groups that offer tertiary care 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**
	CCN shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.			
7.7.7	Direct Access to Women's Health Care - The CCN shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that rural and urban members have access to OBGYNs according to access standards set by DHH.	
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	Member Handbook states "You can go to any LaCare or Medicaid doctor or clinic you choose for family planning services. You can choose doctors and clinics not in the LaCare network. You do not need a referral for routine family planning services."	
7.7.7.2	CCN members shall have the freedom to receive family planning services and related supplies from	Substantial	Member Handbook meets most of this requirement; however, the plan should also encourage members to receive family planning services through the plan's	

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**
	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.		network to ensure continuity and coordination of the member's total care.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	Member Handbook details privacy practices, which covers maintaining the confidentiality of each member's medical information.	
7.7.8	Prenatal Care Services	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement. GeoAccess reports show that urban and rural members have access to PCPs and OBGYNs according to the access standards set by DHH.	
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 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.	Full	The Member Handbook meets this requirement.	
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)	Full	The Provider Handbook meets 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**
	business day after birth.			
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 applicable state and federal laws and regulations.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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.	Full	Plan meets this requirement through P/P 124.12.005L (Transportation for emergent and non-emergent care).	
7.7.11	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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.7.11.2	If a CCN is unable to contract with	Minimal	P/P NM 303 (Network Development Management	MCO 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**
	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 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.		Accessibility) does not fully meet this requirement. It states "If a CCN is unable to contract with an FQHC or RHC within the geographic service area and PCP time and distance travel standards, LaCare Network Management notifies Operations".	Updated P&P NM 303 with applicable language. (Attached.) IPRO response: No change in determination, but updated policy will be reviewed as part of next year's audit.
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.	Non-Compliance	Reimbursement is not addressed in the document provided.	MCO response: Updated P&P NM 303 with applicable language. IPRO response: No change in determination, but updated policy will be reviewed as part of next year's audit.
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.7.11.5	The CCN shall inform members of these rights in their member handbooks.	Full	Member Handbook meets this requirement.	
7.7.11.6	The CCN shall not enter into alternative reimbursement arrangements with FQHCs or RHCs without prior approval from DHH.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.7.12	School-Based Health Clinics (SBHCs)	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.7.14	Significant Traditional Providers. The CCN shall make a good faith	Full	P/P NM 303 (Network Development Management Accessibility) meets 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**
	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 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	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet 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**
	network of providers, the CCN shall consider the following:			
7.8.1.1	Anticipated maximum number of Medicaid members;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the CCN;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.1.4	The numbers of CCN providers who are not accepting new CCN members; and	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2	The Network Provider Development and Management Plan shall demonstrate the ability to provide access to Services and shall include:	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.1	Assurance of Adequate Capacity and Services	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet	

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**
			this requirement.	
7.8.2.2	Access to Primary Care Providers	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.3	Access to Specialists	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.4	Access to Hospitals	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.5	Timely Access	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.6	Service Area	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.2.7	Other Access Requirements: Direct Access to Women's Health, Special Conditions for Prenatal Providers, Second Opinion and Out-of-Network Providers.	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
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	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet 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**
	also be included.			
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	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
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 compromised during the grievance/appeal processes;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.5.3	Evaluate the quality of services delivered by the network;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Full	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet 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**
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	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
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	P/P NM 303 (Network Development Management Accessibility) and the LaCare Provider Network Development and Management Plan document meet this requirement.	
7.8.5.7	Provide training for its providers and maintain records of such training;	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement. The plan also submitted their PowerPoint slides, which they use for provider orientation/training.	
7.8.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Full	The plan submitted their Report Submission Schedule to demonstrate that they meet the reporting requirements for provider inquiries/complaints and that they track such information.	
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.	Substantial	The Account Executive Training Manual states that provider calls are addressed within 3 business days of receipt. Provider Handbook states that “LaCare will investigate and conduct an on-site meeting with the network provider (if one was requested), and issue the resolution of the dispute within 30 calendar days of receipt of the formal dispute from the network provider.” The Handbook should also include that if disputes are not resolved in 30 days the plan must document why	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			the issue goes unresolved and the issue must be resolved within 90 days.	
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.	Full	P/P NM 303 (Network Development Management Accessibility) meets this requirement.	
7.8.7	CCN Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	N/A	DHH Responsibility	
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	P/P NM 301 (Provider Termination Process) meets 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**
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	P/P NM 301 (Provider Termination Process) meets this requirement.	
7.9.1.2	A decrease in the total of individual PCPs by more than five percent (5%);	Full	P/P NM 301 (Provider Termination Process) meets this requirement.	
7.9.1.3	A loss of any participating specialist which may impair or deny the members' adequate access to providers;	Full	P/P NM 301 (Provider Termination Process) meets this requirement.	
7.9.1.4	A loss of a hospital in an area where another CCN hospital of equal service ability is not available as required by access standards specified in this RFP; or	Full	P/P NM 301 (Provider Termination Process) meets this requirement.	
7.9.1.5	Other adverse changes to the composition of the CCN which impair or deny the members' adequate access to providers.	Full	P/P NM 301 (Provider Termination Process) meets this requirement.	
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	P/P NM 301 (Provider Termination Process) addresses this requirement.	
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,	Full	Addressed in P/P NM 301 (Provider Termination Process).	

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**
	including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.			
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.	Full	P/P NM 301 (Provider Termination Process) states "If termination is related to network access, the Plan shall include in the notification to DHH their plans to notify Plan members of such change and strategy to ensure timely access to Plan members through out-of-network providers. If termination is related to the Plan's operations, the notification shall include the plan for how it will ensure that there will be not stoppage or interruption of services to members or providers."	
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	DHH responsibility	
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	Substantial	P/P NM 301 (Provider Termination Process) includes immediate member notification under these circumstances. The policy does not address providing notification to DHH within one business day of termination due to unexpected changes.	

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**
	include:			
7.9.6.1	Information about how the provider network change will affect the delivery of covered services, and	Full	P/P NM 301 (Provider Termination Process) states "If termination is related to network access, the Plan shall include in the notification to DHH their plans to notify Plan members of such change and strategy to ensure timely access to Plan members through out-of-network providers. If termination is related to the Plan's operations, the notification shall include the plan for how it will ensure that there will be not stoppage or interruption of services to members or providers."	
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.	Full	P/P NM 301 (Provider Termination Process) states "If termination is related to network access, the Plan shall include in the notification to DHH their plans to notify Plan members of such change and strategy to ensure timely access to Plan members through out-of-network providers. If termination is related to the Plan's operations, the notification shall include the plan for how it will ensure that there will be not stoppage or interruption of services to members or providers."	
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	P/P NM 301 (Provider Termination Process) states "Provider contracts require 90 days written notice when terminated without cause."	
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	Full	P/P NM 303 (Network Development Management Accessibility) meets 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**
	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).			
7.11	**Patient-Centered Medical Home (PCMH)**			
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	The PCMH Implementation Plan document meets this requirement.	
7.11.2	The CCN shall provide a PCMH Implementation Plan within ninety (90) days of the "go live" date that	Full	According to the Network Management Director, the plan was submitted during the Readiness Review the previous year.	

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**
	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:			
7.11.2.1	Payment methodology for payment to primary care practices for the specific purpose of supporting 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;	Minimal	Payment methodology is not addressed in policy. It is recommended that this requirement be added to the PCMH Implementation Plan. The Network Management Director noted onsite that there is an Amerihealth policy document relating to PCMH that has not been finalized, which would contain the contract language required.	MCO response: ACLA reimburses providers for their NCQA or JHACO initial application fee. Updated PCMH Implementation Plan with applicable language. (Attached.) IPRO response: No change in determination, but updated PCMH Plan will be reviewed as part of next year's audit.
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	The PCMH Implementation Plan document meets this requirement.	
7.11.2.3	Facilitation of specialty provider network access and coordination to support the PCMH; and	Full	The PCMH Implementation Plan document meets this requirement.	
7.11.2.4	Facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Full	The PCMH Implementation Plan document meets this requirement.	
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	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	accreditation:			
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	Not addressed in the PCMH Implementation Plan. It is recommended that targets for accreditation are added to the document. According to the Network Management Director, the 7% accreditation that they achieved in the 1st year of operations is lower than the 20% required by the DHH because it usually takes 1 year for the PCMH program to be fully implemented. They anticipate that they would be able to achieve 20% accreditation in their 2nd year of operations. During the interview, the NM Director described how the plan is working towards meeting the 20% goal by next year. It includes training more of their Account Executives who go onsite to become fully accredited to train practices on PCMH and encouraging every practice they visit to work towards getting accredited, i.e. setting goals with the providers to become accredited. DHH extended the date to achieve the year one goal to June 2013.	
7.11.3.2	By the end of the second year of operation under the Contract: • 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.	Non-Compliance	Not addressed in the PCMH Implementation Plan. It is recommended that targets for accreditation be added to the document.	MCO response: Updated PCMH Implementation Plan with applicable language. IPRO response: No change in determination, but updated PCMH Plan will be reviewed as part of next year's audit.
7.11.3.3	By the end of the third year of operation under the Contract:	Non-Compliance	Not addressed in the PCMH Implementation Plan. It is recommended that targets for accreditation be added	MCO response: Updated PCMH Implementation Plan with applicable

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 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.		to the document.	language. IPRO response: No change in determination, but updated PCMH Plan will be reviewed as part of next year's audit.
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	The PCMH Recognition Report meets this requirement.	
7.11.5	The CCN shall participate in Patient-Centered Primary Care Collaborative activities.	Non-Compliance	Not addressed in the PCMH Implementation Plan and no evidence provided to show participation in collaborative.	MCO response: Updated PCMH Implementation Plan with applicable language. IPRO response: No change in determination, but updated PCMH Plan will be reviewed as part of next year's audit.
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	The plan is aware of this requirement but it is not mentioned in the PCMH Implementation Plan. It is recommended that targets for accreditation are added to the document.	
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	Full	The PCMH Recognition Report meets 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**
	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.			
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	P/P 277.010 (Delegation Oversight) states "The Delegation Oversight Committee or its Plan-specific equivalent is responsible for obtaining any further internal and external approvals as may be necessary for the initiation and continuation of a delegated relationship, through the governing internal committee structure and any required external approval process5, including but not limited to the Plan's State Medicaid Agency."	
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 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	Full	P/P NM 303 (Network Development, Management and Accessibility) meets 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**
	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	P/P 210.002 Credentialing and Recredentialing of Providers meets this requirement.	
7.12.3.1	The CCN shall follow the state's credentialing and re-credentialing policy.	Full	P/P 210.002 Credentialing and Recredentialing of Providers meets this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) and P/P 210.002 Credentialing and Recredentialing of Providers meet this requirement.	
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	P/P NM 303 (Network Development, Management and Accessibility) meets this requirement.	
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 any subcontractor, including, but not limited to:	Full	P/P 277.010 (Delegation Oversight) meets this requirement. The plan also submitted a sample of their Delegated Agreement which meets this requirement.	
7.12.5.1	All provider subcontracts must fulfill the requirements that are appropriate to the service or activity delegated under the	Full	P/P 277.010 (Delegation Oversight) meets this requirement. The plan also submitted a sample of their Delegated	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	subcontract.		Agreement which meets this requirement.	
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	P/P 277.010 (Delegation Oversight) meets this requirement.	
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 subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	Full	Contracts submitted for Logisticare, Convey, DentaQuest, VSP, MTM.	
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	P/P 277.010 (Delegation Oversight) meets this requirement.	
7.12.5.6	The CCN shall identify deficiencies or areas for improvement, and take corrective action.	Full	P/P 277.010 (Delegation Oversight) meets this requirement.	
7.12.5.7	The CCN shall specifically deny payments to subcontractors for Provider Preventable Conditions.	Full	It is LaCare's policy to deny payment for PSAEs that occur during an inpatient admission.	
7.12.6	The CCN shall submit all major subcontracts, excluding provider	Non-Compliance	The plan submitted P/P 180.001 (Creation and Approval of Communication Materials) as evidence.	MCO response: This requirement is met in the Delegation P&P

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**
	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.	(Based on a re-review of the Delegation P&P, determination is changed to "Full")	This P/P addresses internal/external communications material and does not specifically address subcontracts. This language should be included in the Delegation P/P.	submitted to IPRO. Please see page 2, under Scope. It states: "The Delegation Oversight Committee or its Plan-specific equivalent is responsible for obtaining any further internal and external approvals as may be necessary for the initiation and continuation of a delegated relationship, through the governing internal committee structure and any required external approval process, including but not limited to the Plan's State Medicaid Agency." IPRO response: Based on a re-review of the Delegation P&P which contains language that meets this requirement, determination is changed to "Full."
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 amendment.	Non-Compliance (Based on a re-review of the Delegation P&P, determination is changed to "Full")	The plan submitted P/P 180.001 (Creation and Approval of Communication Materials) as evidence. This P/P addresses internal/external communications material and does not specifically mention subcontracts. This language should be included in the Delegation P/P.	MCO response: This requirement is met in the Delegation P&P submitted to IPRO. Please see page 2, under Scope. It states: "The Delegation Oversight Committee or its Plan-specific equivalent is responsible for obtaining any further internal and external approvals as may be necessary for the initiation and continuation of a delegated relationship, through the governing internal committee structure and any required external approval process, including but not limited to the Plan's State Medicaid Agency." IPRO response: Based on a re-review of the Delegation P&P which contains language that meets this requirement, determination is changed to "Full."
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	Full	P/P NM 303 (Network Development, Management and Accessibility) meets 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**
	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.			
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.	Full	NM 301 (Provider Termination Process) meets this requirement.	
7.12.10	If termination is related to network access, the CCN shall include in the notification to DHH their plans to 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.	Full	NM 301 (Provider Termination Process) meets 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**
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	NM 301 (Provider Termination Process) meets this requirement.	
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	PCP contract meets this requirement.	
7.13.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	Full	PCP contract meets this requirement.	
7.13.1.2	Any information the member needs in order to decide among relevant treatment options;	Full	PCP contract meets this requirement.	
7.13.1.3	The risks, benefits and consequences of treatment or non-treatment; and	Full	PCP contract meets this requirement.	
7.13.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse	Full	PCP contract meets 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**
	treatment, and to express preferences about future treatment 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**
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	Contract requirement addressed in UM 2013 Program Description.	
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 Program Description, Clinical Practice Guidelines and UM criteria.	
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	Contract requirement addressed in UM criteria.	
8.1.3.2	The data sources and clinical review	Full	Contract requirement met per documentation in	

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**
	criteria used in decision making;		LaCare Provider Handbook.	
8.1.3.3	The appropriateness of clinical review shall be fully documented;	Full	Contract requirement met per documentation in LaCare Provider Handbook.	
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	Full	Contract requirement met per documentation in 8.1.1 Policies & Procedures/ Supporting UM Policies/ UM.003 Non-Urgent and Urgent Care Prior Authorization.	
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	Full	Contract requirement met per documentation in UM criteria.	
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services; and	Full	Contract requirement met per documentation in LaCare Provider Handbook.	
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information.	Full	Contract requirement met per documentation in LaCare Provider Handbook.	
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	Contract requirement met per documentation in QM205.007 Preventive Health and Clinical Practice Guidelines.	
8.1.5	The CCN shall disseminate the practice guidelines to all affected providers and, upon request, to members and potential members.	Full	Contract requirement met per documentation in QM205.007 Preventive Health and Clinical Practice Guidelines and Provider Handbook.	
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 consistently in compliance, based	Full	UM committee responsibilities include Application of clinical practice guidelines per UM 2013 Program Description; LaCare Medical Record Review Policy MM.005L addresses 90% compliance with clinical practice guidelines.	

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**
	on CCN measurement findings. The CCN should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.			
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	Contract requirement met per documentation in 8.1.1.4 Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	
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	Contract requirement met per documentation in 8.1.1.4 Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	
8.1.7.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Full	Contract requirement met per documentation in 8.1.1.4 Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	
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	Contract requirement met per documentation in 8.1.1.4 Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	
8.1.8	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request. Decisions	Full	Contract requirement met per documentation in 8.1.1.4 Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	

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**
	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	Contract requirement met per documentation in UM 2013 Program Description and UM Concurrent Review UM.002L.	
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	Contract requirement met per documentation in 1.1.2/LaCare Provider Manual Letter of Medical Necessity.	
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	Contract requirement met per documentation in UM003L Non-urgent and urgent Care Prior (Pre-Service) Authorization.	
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 necessity determinations. The CCN	Full	Contract requirement met per documentation in Medical Management Criteria/ UM Clinical Criteria P&P UM.008L.	

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**
	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	Contract language in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM 500L LaCare Covered Benefits and Services.	
8.1.14	The CCN must identify the qualification of staff who will determine medical necessity.	Full	Contract requirement met per documentation in UM003L Non-urgent and urgent Care Prior (Pre-Service) Authorization.	
8.1.15	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Full	Contract requirement met per documentation in UM003L Non-urgent and urgent Care Prior (Pre-Service) Authorization.	
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	Contract requirement met per documentation in 8.1.3 UM Program Description.	
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, governmental agency or unit, or	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	

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**
	regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.			
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	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.1.19	The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services.	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
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	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM 500L LaCare 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	Contract language in UM 500L LaCare 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 reasonably be expected to achieve	Full	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM 500L LaCare 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**
	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	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.1.21	The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity Unit.	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
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	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.1.22.2	The name of the enrollee's physician;	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.1.22.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Full	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies /UM.002 Concurrent Review.	
8.1.22.4	The plan of care;	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.1.22.5	Initial and subsequent continued stay review dates;	Full	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies /UM.002 Concurrent Review.	
8.1.22.6	Date of operating room reservation,	Full	Contract requirement met per documentation in 8.1.3	

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**
	if applicable;		UM Program Description.	
8.1.22.7	Justification of emergency admission, if applicable.	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
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	Contract language in 8.1.3 UM Program Description.	
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	Contract language in 8.1.3 UM Program Description.	
8.2.2.1	Monitoring providers' requests for rendering healthcare services to its members;	Full	Contract language in 8.1.3 UM Program Description.	
8.2.2.2	Monitoring the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling;	Full	Contract language in 8.2.1 UM Program Description.	
8.2.2.3	Reviewing the effectiveness of the utilization review process and making changes to the process as needed;	Full	Contract language in 8.2.1 UM Program Description.	
8.2.2.4	Approving policies and procedures	Full	Contract language in 8.2.1 UM Program Description.	

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**
	for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task;			
8.2.2.5	Monitoring consistent application of "medical necessity" criteria;	Full	Contract language in 8.2.1 UM Program Description.	
8.2.2.6	Application of clinical practice guidelines;	Full	Contract language in 8.2.1 UM Program Description.	
8.2.2.7	Monitoring over- and under-utilization;	Full	Contract language in 8.2.1 UM Program Description.	
8.2.2.8	Review of outliers, and	Full	Contract language in 8.2.1 UM Program Description.	
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	Contract language in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	
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	Full	Contract requirements met per documentation in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	

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**
	link the information compiled during the review to other CCN functions (e.g. QI, credentialing, peer review, etc.).			
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 providers.	Full	Contract requirements met per documentation in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	
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	Contract requirements met per documentation in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	
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	Contract requirements met per documentation in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	
8.2.5	The CCN shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Full	Contract language in 8.1.1.5 Medical Record Review Process and Tools/LaCare Medical Record Review P&P 205.005.	
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	Full	Contract requirements met per documentation in 8.2.5 UM Reports, e.g., UM Committee Meeting Minutes included note regarding forwarding information to DHHS.	

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**
	CCN of additional required reports no less than 30 days prior to due date of those reports			
8.4	**Service Authorization**			
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	Full	Contract language in 8.1.1 Policies & Procedures/Supporting UM Policies /UM.003 Non Urgent and Urgent Care Prior 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	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Full	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies /UM.003 Non Urgent and Urgent Care Prior Authorization.	
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	Full	Contract language in 8.1.3 UM Program Description.	

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 clinical expertise in treating the enrollee's condition or disease;			
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	Full	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies/UM.002L Concurrent Review.	
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	Full	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.010L Decision Notification Timeframes.	
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.	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
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 appropriate medical information	Full	Contract requirement regarding timing met in 8.1.3 UM Program Description, with 80% timing requirement indicated in grid by asterisk per plan during on-site visit 9/30/13.	

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**
	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	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.010L Decision Notification Timeframes.	
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.	Substantial	8.1.3 UM Program Description addresses requirement. On-site file review: 17 of 20 UM Denials met the timeliness requirement.	
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 authorization decision and provide	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	

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**
	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.	Full	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.010L Decision Notification Timeframes. In a communication after the onsite audit was conducted, DHH 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	Contract language in 8.1.3 UM Program Description.	
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.	Full	Contract language in 8.1.3 UM Program Description.	
8.5.1.4	Timing of Notice	N/A		
8.5.1.4.1	Notice of Action	N/A		
8.5.1.4.1.1	Approval [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**
8.5.1.4.1.1.1	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	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.010L Decision Notification Timeframes.	
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	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.010L Decision Notification Timeframes.	
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	Contract language in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.017L Notice of Adverse Determination.	
8.5.1.4.2.2	Adverse - The CCN shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.	Full	Contract requirement met per documentation in 8.1.1 Policies and Procedures/ Supporting UM Policies/ UM.017L Notice of Adverse Determination.	

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**
8.5.1.5	Informal Reconsideration	N/A	Contract requirement met per documentation in 8.1.1.1/Utilization Management including informal reconsiderations/ UM P&P Peer to Peer Discussion UM.105L.	
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	Contract requirement met per documentation in UM.105L Peer to Peer Discussion.	
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.	Full	Contract requirement met per documentation in 8.1.1.1 – Utilization Management including informal reconsiderations – Peer to Peer P&P UM P&P Peer to Peer Discussion UM.105L .	
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 clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	Minimal	Contract requirement met per documentation in 8.1.1.1 – Utilization Management including informal reconsiderations – Peer to Peer P&P UM P&P Peer to Peer Discussion UM.105L. On-site file review findings showed that none of the Informal Reconsideration files reviewed met the one day time notification requirement. Item discussed at on-site interview. Plan and DHH discussed how peer-to-peer review and informal reconsideration may be considered as two distinct processes; however, the NCQA requirement for 1 day response to request for informal consideration was acknowledged by all, as well as the need to incorporate	MCO response: The contract language appears to mesh two different processes. The plan meets the "informal reconsideration" bullet cited by offering a Peer-to-Peer discussion at the time of giving verbal notification of adverse determination within the 1 working day of the receipt of the request; however, written member consent is not obtained. We are pending feedback from DHH on whether we may waive the consent requirement thus meeting the contract obligation with our Peer-to-Peer review. We have a second process termed informal reconsideration; however, this is part of our standard appeals process and the provider is typically not involved. Additional clarification on DHH intent surrounding 8.5.1.5 is requested, as we view

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**
			this requirement into the plan system and plan informal reconsideration letter (which currently identifies a notification timeframe of 30 days instead of the required one day), and to reconcile NCQA requirement with DHH processes available for both Peer-to-peer and informal reconsideration processes.	informal reconsideration and Peer-to-Peer review as two distinct processes. IPRO response: Determination remains unchanged. However, plan response is noted and will be provided to DHH for further review of the "Informal Consideration" process and the interpretation of what constitutes compliance with the one day timeliness standard.
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	Contract requirement met per documentation in 8.1.1.1 – Utilization Management including informal reconsiderations – Peer to Peer P&P UM P&P Peer to Peer Discussion UM.105L.	
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	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies/UM.905L Emergency Room Services.	
8.5.1.6.2	The CCN shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	Non-Compliance	Provider manual includes "Normal Newborns Deliveries" as a service requiring prior authorization. Discussed at on-site visit: Plan indicated onsite that it will update the provider manual to clarify that continuing authorization is required for vaginal delivery stays >48 hours and for c-section stays >96 hours only.	MCO response: Provider manual updated to remove normal newborn deliveries under services requiring prior authorization. (Updated page attached.) IPRO response: No change in determination, but change is noted and updated provider manual will be reviewed as part of next year's audit.
8.5.1.6.3	The CCN shall not require service authorization or referral for EPSDT screening services.	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	
8.5.1.6.4	The CCN shall not require service authorization for the continuation of medically necessary covered services of a new member	Full	Contract requirement met per documentation in 8.1.3 UM Program Description.	

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**
	transitioning into the CCN, regardless of whether such services are provided by an in-network or out-of-network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days.			
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	Contract requirement met per documentation in 8.1.1 Policies & Procedures/Supporting UM Policies/UM.706 Continuity of Care.	
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	Contract requirement met per documentation in 1.1.2 LaCare Provider Manual.	
8.5.1.6.7	The CCN shall not require a PCP referral for in-network eye care and vision services.	Non-Compliance	Contract language contained in 8.1.3 UM Program Description. 1.1.2/LaCare Provider Manual states "the PCP should initiate appropriate referrals and/or authorizations for all non-routine eye care services" Discussed during onsite visit, per MCO, referral statement should be removed.	MCO response: Provider manual updated to remove referral statement. (Updated page attached.) IPRO response: No change in determination, but change is noted and updated provider manual will be reviewed as part of next year's audit.
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	Full	Contract requirement met per documentation in 1.1.2/LaCare 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**
	(96) hours after caesarean section.			
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 and/or as requested by DHH, for purposes of making medical necessity determinations.	Full	Contract requirement met per documentation in 1.1.2/LaCare Provider Manual Letter of Medical Necessity.	
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	Contract requirement met per documentation in 1.1.2/LaCare Provider Manual Letter of Medical Necessity.	
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	Contract requirement met per documentation in 1.1.2/LaCare Provider Manual Letter of Medical Necessity.	
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	Contract requirement met per documentation in 1.1.2/LaCare Provider Manual Letter of Medical Necessity.	
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	Contract requirement met per documentation in Quality of Clinical Care Report 2nd QTR 2013.pdf (identifies quality issues).	

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**
			The following reports were provided that documented UM tracking as required: ✓ HEDIS Interim Report, e.g., underutilization ✓ Pharmacy report, e.g., overutilization ✓ Medical Loss Unit Report, e.g., overutilization ✓ Fraud & Abuse Activity Report, e.g., outliers.	
8.7.2	The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Full	Contract requirement met per documentation in Quality of Clinical Care Report 2nd QTR 2013.pdf (Identifies outcome determinations, whether a corrective action plan was needed, and whether the case was referred to Quality or Credentialing Committee).	
8.7.3	The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall include, but are not limited to, the following:	Full	066 LAC2013 Q1 docx; 066 LAC2013 Q2.docx address UM and reporting to DHH.	
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	Addressed in Quarterly DHH Report PQ072.During the onsite visit, plan described process and procedures to handle out-of-network requests that address continuity of care, provider geographic accessibility, specialty needs met.	
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	Addressed in Quarterly DHH Report PQ072.	
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	Addressed in Quarterly DHH Report PQ072.	
8.7.3.4	Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a	Full	Addressed in Quarterly DHH Report PQ072.	

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**
	procedure to identify and evaluate member's utilization; and			
8.7.3.5	Individual PCP clinical quality performance measures as indicated in Appendix J.	Full	Addressed in Quarterly DHH Report PQ072.	
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	Addressed in Quarterly DHH Report PQ072.	

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	Substantial	The Provider Handbook is only available online. The Handbook states that printed materials such as the Handbook are available on the website, which includes the web address. The plan should provide written notification to providers advising them that the Handbook is available online. During the interview, the plan disclosed that the Provider Handbook is revised as needed. Revisions to the handbook are relayed to providers via the quarterly newsletters, through fax blasts or through their	

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 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:		Account Executives.	
10.4.1.1	Description of the CCN;	Full	The Provider Handbook meets this requirement.	
10.4.1.2	Description and requirements of Patient-Centered Medical Home recognition;	Full	The Provider Handbook meets this requirement.	
10.4.1.3	Core benefits and services the CCN must provide;	Full	The Provider Handbook meets this requirement.	
10.4.1.4	Emergency service responsibilities;	Full	The Provider Handbook meets this requirement.	
10.4.1.5	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;	Full	The Provider Handbook, P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
10.4.1.6	Information about the CCN's Grievance System, that the provider may file a grievance or appeal on	Full	The Provider Complaint System workflow, P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this	

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**
	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;		requirement.	
10.4.1.7	Medical necessity standards as defined by DHH and practice guidelines;	Full	The Provider Handbook meets this requirement.	
10.4.1.8	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Full	The Provider Handbook meets this requirement.	
10.4.1.9	PCP responsibilities;	Full	The Provider Handbook meets this requirement.	
10.4.1.10	Other provider responsibilities under the subcontract with the CCN;	Full	The Provider Handbook meets this requirement.	
10.4.1.11	Prior authorization and referral procedures;	Full	The Provider Handbook meets this requirement.	
10.4.1.12	Medical records standards;	Full	The Provider Handbook meets this requirement.	
10.4.1.13	Claims submission protocols and standards, including instructions and all information necessary for a clean and complete claim and samples of clean and complete claims;	Full	The Provider Handbook meets this requirement.	
10.4.1.14	CCN prompt pay requirements;	Full	The Provider Handbook meets this requirement.	
10.4.1.15	Notice that provider complaints regarding claims payment shall be sent to the CCN;	Full	The Provider Handbook meets this requirement.	
10.4.1.16	The CCN's chronic care management program;	Full	The Provider Handbook meets this requirement.	
10.4.1.17	Quality performance requirements;	Full	The Provider Handbook meets this requirement.	

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**
	and			
10.4.1.18	Provider rights and responsibilities.	Full	The Provider Handbook meets this requirement.	
10.4.2	The CCN shall disseminate bulletins as needed to incorporate any changes to the provider handbook.	Full	During the interview, the plan disclosed that the Provider Handbook is revised as needed. Revisions to the handbook are relayed to providers via the quarterly newsletters, through fax blasts or through their Account Executives. Recommend that the plan consider other ways of notifying providers of updates to the handbook especially if the change is substantial and cannot wait until the quarterly newsletter. The fax blasts are one way; however, provider office fax machines are usually flooded with other incoming faxes and the information could easily be missed. Emails to provider offices are another possibility. The notification should be easy to read, highlight which sections are affected, and it should encourage the provider to download the latest handbook from the website.	
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	The Provider Complaint System workflow, P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
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	The Provider Handbook meets this requirement.	
10.6.1.2	Identify a staff person specifically designated to receive and process	Full	The Provider Handbook meets this requirement and P/P 124.12.06 (Informal Provider Disputes) meets this	

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 complaints;		requirement.	
10.6.1.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the CCN's written policies and procedures; and	Full	P/P 124.12.06 (Informal Provider Disputes) states, "The Plan shall 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 Plan shall document why the issue goes unresolved; however, the issue must be resolved within 90 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	The Provider Handbook meets this requirement.	
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	The Provider Complaint System workflow, P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
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;	Full	The Provider Complaint System workflow, P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
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 provider may file a complaint	Full	The Provider Handbook meets this requirement.	

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**
	directly to DHH/MMIS for those decisions that are not a unique function of the CCN;			
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;	Full	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
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	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
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	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
10.6.2.6	A description of the methods used to ensure that CCN executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	Full	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
10.6.2.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Full	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
10.6.2.8	Identification of specific individuals who have authority to administer the provider complaint process;	Full	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	
10.6.2.9	A system to capture, track, and	Substantial	Provider complaints are stored electronically in the EXP	

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**
	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		MACESS system. **<u>Provider Complaint File Review</u>** A total of 20 provider complaint files were reviewed. Of the 20 files, 16 were fully compliant. The final resolution was not clear in 4 of the files: o 3 files were considered "closed" but there was no resolution in the documentation. o 1 file that was considered "closed" had the following issues: - The determination letter did not contain the rationale. - The letterhead/stationary used by the specialist was for the old company rather than LaCare. Although the 16 cases that were fully compliant were also resolved timely, there were 2 cases where the resolution was unnecessarily delayed because another department had to be involved. The plan acknowledged that systems/workflows needed to be reviewed to ensure that periodic follow-ups by complaints specialists are integrated into the system/workflow to avoid unnecessary delays in the resolution.	
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	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement. The plan submitted their Report Submission Schedule for this Q4 2013 to show that they have systems in place to produce the complaints reports on a timely basis.	
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	Full	P/P 124.12.06 (Informal Provider Disputes) and P/P 124.12.07 (Formal Provider Disputes) meet this requirement.	

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**
	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 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	The Provider Handbook meets this requirement.	
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.	Full	The Provider Handbook meets this requirement.	

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 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.			
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	Provider Handbook (Fair Hearing Procedures) meets this requirement.	
10.6.3.3	Within fifteen (15) business days of the mailing of the Notice of Adverse Action, the aggrieved provider may request an administrative hearing with the Division of Administrative Law (DAL) by filing a request for administrative hearing with the DAL. After a decision is rendered by the DAL, the aggrieved provider may seek judicial review of the DAL decision within thirty (30) days of the date the final decision is mailed to the parties, pursuant to La. R.S. 49:964. The judicial review petition shall be filed with the 19th Judicial District Court. The District Court's judgment may be appealed, by an aggrieved party within the appeal time delays set forth in the Louisiana Code of Civil Procedure.	Full	Provider Handbook (Fair Hearing Procedures) meets this requirement.	

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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
11.11.1.2	Selects a PCP within the CCN that has reached their maximum physician/patient ratio; or	Full	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
11.11.1.3	Selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).	Full	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	

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.	Full	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010) and the Member Handbook.	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010). The Policy states: "The Member may change the PCP selection at any time for any reason."	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010). The Policy states: "The Member may change the PCP selection at any time for any reason."	
11.11.8	If a member requests to change his or her PCP with cause, at any time	Full	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care	

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.		Physicians Policy (124.12.010). The Policy states: "The Member may change the PCP selection at any time for any reason."	
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	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010.).	
11.11.11	The CCN shall notify the Enrollment Broker by close of business the next business day of a PCP's termination.	Full	This requirement was addressed in the Assigning Primary Care Physicians and Changing Primary Care Physicians Policy (124.12.010).	
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 the member is no longer eligible for Medicaid or the CCN Program. The CCN shall submit to DHH a Quarterly CCN Disenrollment	Full	This requirement was addressed in the Member Initiated Disenrollment and Enrollment Policy (124.12.017).	

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**
	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 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.	Full	This requirement was addressed in the Member Initiated Disenrollment and Enrollment Policy (124.12.017).	

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**
11.12.1.2	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	This requirement was addressed in the Member Initiated Disenrollment and Enrollment Policy (124.12.017).	
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	This requirement was addressed in the Member Initiated Disenrollment and Enrollment Policy (124.12.017).	
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	This requirement was addressed in the Member Initiated Disenrollment and Enrollment Policy (124.12.017).	
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 medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her	Full	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	

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**
	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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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 the extent that enrollment in the CCN seriously impairs the organization's ability to furnish services to either the member or other members.	Full	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	

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**
11.12.2.4	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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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 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	Full	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	

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**
	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.	Full	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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	This requirement was addressed in the Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001).	
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 CCN enrollment eligibility;	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.2	Death of a member;	Substantial	The Plan Initiated Disenrollment and Enrollment	

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**
			Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.3	Member's intentional submission of fraudulent information;	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.4	Member becomes an inmate in a public institution;	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.5	Member moves out-of-state;	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.6	Member becomes Medicare eligible;	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.7	Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.8	Member becomes a participant in a	Substantial	The Plan Initiated Disenrollment and Enrollment	

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**
	home and community-based services waiver;		Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
11.12.3.9	Member elects to receive hospice services; and	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	
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.	Substantial	The Plan Initiated Disenrollment and Enrollment Transition Policy (124.12.001) states: *"DHH notifies us that they are initiating disenrollment of the member".* The reasons for DHH initiated disenrollment should be added to the policy.	

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	This requirement is address addressed in Member Education Materials policy (164.402.01).	
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	This requirement is address addressed in Member Education & Communication (124.12.004).	
12.11.1.2	The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed	Full	This requirement is addressed in Member Education & Communication (124.12.004) – in the Welcome Script. LaCare conducted an ER Utilization PIP for MY 2012.	
12.11.1.3	The CCN may propose, for approval by DHH, alternative methods for orienting new members and must	Full	This requirement is addressed in the Member Materials – Development and Approval P&P (205.100).	

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.			
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	This requirement is addressed in Member Education & Communication P&P (124.12.004).	
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	This requirement is addressed in the Member Materials – Development and Approval P&P (205.100).	
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	This requirement is addressed in the Auto Assigning Methodology and the Assigning PCP P&P (123.12.101).	
12.11.2	**Communication with New Enrollees**			
12.11.2.1.1	The CCN shall send a welcome	Full	This requirement is addressed in Member Education &	

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.		Communication P&P (124.12.004).	
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.	Full	This requirement is addressed in Member Education & Communication P&P (124.12.004).	
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	This requirement is addressed in Member Education & Communication P&P (124.12.004) and in Member Education & Communication P&P (124.12.004). The Welcome Letter was presented during the onsite for review.	
12.11.2.1.3.2	A Member Handbook;	Full	This requirement is addressed in Member Education & Communication (124.12.004). The Member Handbook was reviewed during the onsite.	
12.11.2.1.3.3	The CCN Member ID Card; and	Full	This requirement is addressed in Member Education & Communication (124.12.004).	

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**
12.11.2.1.3.4	A Provider Directory (also must be available in searchable format on-line).	Full	This requirement is addressed in Member Education & Communication (124.12.004).	
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	Addressed in the Member Handbook.	
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	This requirement is addressed in Member Education & Communication (124.12.004).	
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	This requirement is addressed in Member Education & Communication (124.12.004).	
12.11.2.3.2.2	Statement of confidentiality;	Full	This requirement is addressed in Member Education & Communication (124.12.004).	
12.11.2.3.2.3	The availability of oral interpretation and written translation services and how to obtain them free of charge;	Full	This requirement is addressed in Member Education & Communication (124.12.004).	
12.11.2.3.2.4	The concept of the patient-centered	Full	This requirement is addressed in Member Education &	

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**
	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		Communication (124.12.004).	
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	This requirement is addressed in Member Education & Communication (124.12.004).	
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	This requirement is addressed in Member Education & Communication (124.12.004).	
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 successfully make contact.	Full	This requirement is addressed in Member Education & Communication (124.12.004). The Unable to Contact Report (PS097) also shows compliance for this standard.	
12.12	**CCN Member Handbook**			
12.12.1	The CCN shall develop and maintain a member handbook.	Full	The Member Handbook was provided for review.	
12.12.2	Member handbook shall include the following information:	N/A	The Member Handbook was provided for review.	
12.12.2.1	Table of contents;	Full	This requirement is 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**
12.12.2.2	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	This requirement is addressed in the Member Handbook.	
12.12.2.3	Member's right to disenroll from CCN;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.4	Member's right to change providers within the CCN;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.5	Any restrictions on the member's freedom of choice among CCN providers;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.6	Member's rights and protections;	Full	This requirement is 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	This requirement is addressed in the Member Handbook.	
12.12.2.8	Procedures for obtaining benefits, including prior authorization requirements;	Full	This requirement is 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	This requirement is 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**
12.12.2.10	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	This requirement is addressed in the Member Handbook.	
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	This requirement is addressed in the Member Handbook.	
12.12.2.11.2	That prior authorization is not required for emergency services;	Full	This requirement is 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	This requirement is 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	This requirement is addressed in the Member Handbook.	
12.12.2.11.5	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the CCN; and	Substantial	The Member Handbook addresses this requirement as follows: *Your LaCare benefits include, but are not limited to the following services:* • *Emergency care is always covered whether provided at a participating or non-participating provider* Recommended that post-stabilization services covered by the plan be added to 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
12.12.2.11.6	That the member has a right to use any hospital or other setting for emergency care.	Full	This requirement is addressed in the Member Handbook.	
12.12.2.12	The post-stabilization care services rules;	Full	This requirement is 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	This requirement is 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	This requirement is addressed in the Member Handbook.	
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	This requirement is 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	This requirement is addressed in the Member Handbook.	
12.12.2.17	Member grievance, appeal and state fair hearing procedures and time frames;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18	Grievance, appeal and fair hearing	N/A		

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	procedures that include the following:			
12.12.2.18.1	For State Fair Hearing: The right to a hearing;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18.2	The method for obtaining a hearing; and	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18.3	The rules that govern representation at the hearing.	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18.4	The right to file grievances and appeals;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18.5	The requirements and timeframes for filing a grievance or appeal;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.18.6	The availability of assistance in the filing process;	Full	This requirement is 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	This requirement is 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	This requirement is 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	This requirement is addressed in the Member Handbook.	
12.12.2.18.10	In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the DHH who has final authority to determine whether	Full	This requirement is 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**
	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	This requirement is 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	This requirement is 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	This requirement is 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.	Full	This requirement is addressed in the Member Handbook.	
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	This requirement is 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**
12.12.2.21	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Full	This requirement is 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	This requirement is addressed in the Member Handbook.	
12.12.2.23	How to obtain emergency and non-emergency medical transportation;	Full	This requirement is addressed in the Member Handbook.	
12.12.2.24	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Full	This requirement is 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	This requirement is 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	This requirement is addressed in the Member Handbook.	
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	Full	This requirement is 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**
	loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;			
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	This requirement is addressed in the Member Handbook. Examples in Spanish and Vietnamese were provided during the onsite.	
12.12.2.29	Information on the member's right to a second opinion at no cost and how to obtain it;	Full	This requirement is 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	This requirement is 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 Complaint Form.	Full	This requirement is addressed in the Member Handbook.	
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,	Full	This requirement is addressed in the Member ID Card P&P (124.12.009).	

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**
	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.			
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 Authorization and Reporting Medicaid Fraud (1-800-488-2917).	Full	This requirement is addressed in the Member ID Card P&P (124.12.009).	
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	This requirement is addressed in the Member ID Card P&P (124.12.009).	

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**
12.13.3	The card will be issued without the PCP information if no PCP selection has been made on the date of the mailing.	Full	This requirement is addressed in the Member ID Card P&P (124.12.009).	
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	This requirement is addressed in the Member ID Card P&P (124.12.009).	
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	This requirement is addressed in the Member ID Card P&P (124.12.009).	
12.13.6	The holder of the member identification card issued by the CCN shall be a CCN member or guardian of a member. If the CCN has knowledge of any CCN member permitting the use of this identification card by any other person, the CCN shall immediately report this violation to the Medicaid Fraud Hotline number 1-800-488-2917.	Full	This requirement is addressed in the Member ID Card P&P (124.12.009).	
12.13.7	The CCN shall ensure that its subcontractors can identify	Full	This requirement is addressed in the Member ID Card P&P (124.12.009).	

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**
	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.			
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	This requirement is addressed in the Provider Directory Policy.	
12.14.1.2	Web-based, searchable, online directory for members and the public; and	Full	This requirement is addressed in the Provider Directory Policy.	
12.14.1.3	Electronic file of the directory for the Enrollment Broker.	Full	This requirement is addressed in the Provider Directory Policy.	
12.14.1.4	Hard copy, abbreviated version for the Enrollment Broker.	Full	This requirement is addressed in the Provider Directory Policy.	
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	Full	This requirement is addressed in the Provider Directory Policy.	

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**
	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.			
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 Medicaid enrollee's service area, including identification of providers, PCPs, specialists, and hospitals at a minimum, that are not accepting new patients;	Full	This requirement is addressed in the Provider Directory Policy.	
12.14.4.2	Identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area;	Full	This requirement is addressed in the Provider Directory Policy.	
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	Full	This requirement is addressed in the Provider Directory Policy.	
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8	Full	This requirement is addressed in the Provider Directory presented as evidence during the onsite review.	

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**
	a.m. or after 5 p.m. or any weekend hours).			
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	The Member Call Center is located in Philadelphia, PA.	
12.15.1.1	Explanation of CCN policies and procedures;	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.2	Prior authorizations;	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.3	Access information;	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.4	Information on PCPs or specialists;	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.5	Referrals to participating specialists;	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.6	Resolution of service and/or medical delivery problems; and	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.1.7	Member grievances.	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
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	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.15.3	The toll-free line shall have an automated system, available 24-hours a day, seven days a week.	Substantial	This requirement is partly addressed in the Contact Center Scope P&P (124.12.012).	

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**
	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.		It is recommended that the plan include in the P&P instructions as to how to leave a message and when that message will be returned. The plan 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.	
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 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.	Full	Addressed in the Contact Center Scope P&P (124.12.012).	
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	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	

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**
	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.			
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 record to document a synopsis of all calls. The tracking shall include sufficient information to meet the reporting requirements.	Full	Addressed in the Contact Center Scope P&P (124.12.012).	
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	This requirement is addressed in the Call Center Auditing P&P (124.05.001).	
12.16	**ACD System**			

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	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	This requirement is addressed in Contact Center Scope (124.12.012) and ACD System (124.12.014).	
12.16.1.2	Transfer calls to other telephone lines;	Full	This requirement is addressed in Contact Center Scope (124.12.012) and ACD System (124.12.014).	
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	This requirement is addressed in Contact Center Scope (124.12.012) and ACD System (124.12.014).	
12.16.1.3	Provide a message that notifies callers that the call may be monitored for quality control purposes;	Full	This requirement is addressed in the Contact Center Scope (124.12.012) P&P.	
12.16.1.4	Measure the number of calls in the queue at peak times;	Full	This requirement is addressed in the ACD System (124.12.014) P&P.	
12.16.1.5	Measure the length of time callers are on hold;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.1.5.1	Measure the total number of calls and average calls handled per day/week/month;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.1.6	Measure the average hours of use per day;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	

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
12.16.1.7	Assess the busiest times and days by number of calls;	Full	This requirement is addressed in the Contact Center Scope (124.12.012) P&P.	
12.16.1.8	Record calls to assess whether answered accurately;	Full	This requirement is addressed in the Call Center Auditing P&P (124.05.001).	
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	This requirement is addressed in the Call Center Auditing P&P (124.05.001). The Call Center is located in South Carolina; the backup system operates in Philadelphia, PA.	
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	This requirement is addressed in Contact Center Scope (124.12.012) and Call Center Monitoring Reports (PS107).	
12.16.1.9	Inform the member to dial 911 if there is an emergency.	Full	This requirement is addressed in the ACD System (124.12.014) P&P.	
12.16.2	Call Center Performance Standards	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.2.1	Answer ninety (90) percent of calls within thirty (30) seconds or an automatic call pickup system;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.2.2	No more than one percent (1%) of incoming calls receive a busy signal;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.2.3	Maintain an average hold time of three (3) minutes or less;	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.2.4	Maintain abandoned rate of calls of not more than five (5) percent.	Full	This requirement is addressed in the Call Center Monitoring Reports (PS107).	
12.16.2.4.1	The CCN must conduct ongoing quality assurance to ensure these standards are met.	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	
12.16.2.4.2	If DHH determines that it is necessary to conduct onsite monitoring of the CCN's member	Full	This requirement is addressed in the Contact Center Scope P&P (124.12.012).	

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**
	call center functions, the CCN is responsible for all reasonable costs incurred by DHH or its authorized agent(s) relating to such monitoring.			
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	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook also shows compliance for this standard.	
12.16.3	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook also shows compliance for this standard.	
12.16.4	**Member Responsibilities**			
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	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for 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**
	serious side effects and complications occur, and/or worsening of the condition arises.			
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	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.2	Presenting their CCN ID card when using health care services;	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.3	Being familiar with the CCN procedures to the best of the member's abilities;	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.4	Calling or contacting the CCN to obtain information and have questions answered;	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.5	Providing participating network providers with accurate and complete medical information;	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.6	Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for 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**
	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	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
12.16.4.2.8	Following the grievance process established by the CCN if they have a disagreement with a provider; and	Full	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
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	This requirement is addressed in the Member Rights and Responsibilities P&P (124.01.004). The Member Handbook shows compliance for this standard.	
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	This requirement is addressed in the Provider Termination P&P (NM 301).	
12.17.2	The CCN shall provide notice to a	Full	This requirement is addressed in the Provider	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.		Termination P&P (NM 301).	
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	This requirement is addressed in the Provider Termination P&P (NM 301).	
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	LaCare Newsletters were presented for review. The Marketing and Member Education Events schedule was provided as evidence for this standard. The report also contained a list of the materials that were distributed during these events.	
12.18.2	Literature, including brochures and	Full	The plan submitted as evidence for this standard four	

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**
	posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;		member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. This requirement is addressed in Creation and Approval of Internal and External Communications Materials; Use of LaCare Logo (180.001).	
12.18.3	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Full	The plan submitted as evidence for this standard four member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. Recommend that the MCO include this standard in the Member Materials – Development and Approval P&P (205.100).	
12.18.4	Materials focused on health promotion programs available to the members;	Full	The plan submitted as evidence for this standard four member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. Recommend that the MCO include this standard in the Member Materials – Development and Approval P&P (205.100).	
12.18.5	Communications detailing how members can take personal responsibility for their health and self management;	Full	The plan submitted as evidence for this standard four member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. Recommend that the MCO include this standard in the Member Materials – Development and Approval P&P 205.100).	

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**
12.18.6	Materials that promote the availability of health education classes for members;	N/A	LaCare does not currently offer Health Education Classes. Recommendation that the plan should consider offering health education classes for members; especially those at-risk or with chronic conditions.	
12.18.7	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Full	The plan submitted as evidence for this standard four member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. Recommend that the MCO include this standard in the Member Materials – Development and Approval P&P (205.100).	
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	The plan submitted as evidence for this standard four member newsletters (that were sent quarterly), flyers and brochures (in several languages) that addressed preventative health guidelines and issues relating to chronic diseases. Recommend that the MCO include this standard in the Member Materials – Development and Approval P&P (205.100).	
12.18.9	Notification to its members their right to request and obtain the welcome packet at least once a year;	Full	This requirement was addressed in the Fall 2012 Member Newsletter. Recommend to add this requirement to the Member Handbook.	
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	Substantial	The plan indicated that no changes were identified by DHH. Even though no changes were identified, plan should incorporate the notification requirement in either a policy or its Member Handbook in the event there are changes in the future.	
12.18.11	All materials distributed must comply with the relevant guidelines established by DHH for these	Full	This requirement was addressed in the Member Materials P&P (164.402.1).	

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**
	materials and/or programs.			
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	This requirement was addressed in the Member Materials P&P (164.402.1).	
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 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.	Full	This requirement was addressed in the Member Materials P&P (164.402.1).	
12.20	**Marketing Reporting and Monitoring**			

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**
12.20.1	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	This requirement was addressed in the Marketing and Member Education Materials Distributed report. This requirement was addressed in the Marketing and Member Education Events report.	
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	This requirement was addressed in the Marketing and Member Education Materials Distributed report. This requirement was addressed in the Marketing and Member Education Events report.	

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	Contract requirements met per documentation in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in Policy and Procedure document, "Member Grievances, Appeals and State Fair Hearing"	
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	Contract requirements met per documentation in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: 20 of 20 grievance cases reviewed contained the date the grievance was received. 20 of 20 grievance cases reviewed contained documentation of the nature of the grievance. 20 of 20 cases reviewed contained documentation of an appropriate investigation of the issues, though 2 were not completed timely.	
13.0.4	The member must exhaust the CCN's internal grievance/appeal procedures prior to accessing the State Fair Hearing process.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
13.0.5	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 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.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	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.			
13.1.2	Definition of Appeal - An appeal is defined as a request for review of an action.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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.	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: The majority of grievance cases (11) were related to transportation. Many of these cases were miss-classified, for example, as "Level of Care" or "Accessibility of Office". LaCare indicated that calls initially go to the Call Center and may be miss-classified, but are re-classified at LaCare by the staff members who work the grievance cases. The plan further stated that the DHH reports use the corrected case type. The re-classification was not evident in the review of the files. It was suggested that LaCare develop mechanism to record the re-categorization so that it is evident to an outside reader and to further ensure the correct category is captured for DHH reports.	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: Twenty-one (21) case files were reviewed. One case was excluded as it was an appeal, resulting in a total of 20 files.	

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**
13.2.2	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, and may request a State Fair Hearing, once the CCN's appeals process has been exhausted.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal request.			
13.3	**Notice of Grievance and Appeal Procedures**			
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.	Full	Contract requirements met per documentation in 3.1.2 – Member Handbook	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	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.			
13.4.2	The CCN shall electronically provide 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.	Full	At on-site review, plan provided documentation that reporting was changed to quarterly per DHH 12/5/12.	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – 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**
	grievance and appeal in writing;		Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: 20 of 20 grievance files contained a written acknowledgement letter.	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: This was not applicable for 20 of 20 cases, as none of the grievances involved clinical issues.	
13.5.2	Special Requirements for Appeals The process for appeals must:	N/A		
13.5.2.1	Provide that oral inquiries seeking	Full	Contract language in 4.1.1.1 – 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**
	to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) 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.		Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.5.3	Training of CCN Staff - The CCN's staff shall be educated concerning	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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	On site file review findings: Items 13.6.2.1-7 addressed in all adverse action letters reviewed 9/30/13.	
13.6.2.1	The action the CCN or its contractor has taken or intends to take;	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). On site file review findings: Items 13.6.2.1-7 addressed in all adverse action letters reviewed.	
13.6.2.2	The reasons for the action;	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.2.3	The member's or the provider's right to file an appeal with the CCN;	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.2.4	The member's right to request a State Fair Hearing, after the CCN's appeal process has been exhausted;	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.2.5	The procedures for exercising the rights specified in this section;	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.2.6	The circumstances under which expedited resolution is available and how to request it; and	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.3	Timing of Notice of Action The CCN must mail the Notice of Action within the following	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**
	timeframes:			
13.6.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.3.2	For denial of payment, at the time of any action affecting the claim.	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). At on-site review, plan Director of Regulatory Compliance shared DHH notice of 4/25/13 regarding "In instances where services were already provided, the member should not be sent a notification of the denial." On-site file review findings: 17 of 20 denials met notification timeframe requirements.	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
13.6.3.4	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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.6.3.5	On the date the timeframe for service authorization expires.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	request) a need for additional information and how the extension is in the member's interest.			
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 as the member's health condition requires, within the timeframes established in 13.7.1 below.	N/A		
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.	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: 20 of 20 cases included the date the grievance was received. 18 of 20 cases were resolved timely. Two cases were lost to follow up, though LaCare noted this in September 2013 and took follow up action. Nonetheless, there were no resolution letters for these 2 cases. LaCare was aware of these cases and agreed.	
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	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). On-site file review findings: 18 of 20 appeals met timeliness requirement.	

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**
	under 13.7.2 of this section.			
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.	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). Grievance File Review: 18 of 20 grievance files reviewed contained a resolution letter with the required contents, including the resolution result in easily understood language. All 20 case files contained documentation of the resolution and rationale, though 2 of the cases were not timely as they were lost to follow-up until September 2013. These 2 cases were not compliant with requirements related to timeliness, resolution and rationale, investigation, and resolution notice. LaCare was aware of these cases and agreed. There was one complaint about a member's usual vision provider not being in the plan's (VSP subcontractor) network and another regarding difficulty finding a participating dentist who was taking new patients in the member's geographical area. The first member could have been advised that the plan would attempt to recruit the vision provider. LaCare could have contacted VSP to do so. As for the dental access issue, the plan could have contacted Dentaquest to request that the vendor assess the number of dental providers not currently in its network and attempt to recruit them. Per LaCare, vendor issues go through corporate offices, but could be addressed through the local office.	
13.7.2	Extension of Timeframes. The CCN may extend the timeframes from 13.7.1 of this section by up to	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	fourteen (14) calendar days if: the member requests the extension; or the CCN shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest. 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.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Substantial	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008). On-site interview: the plan clarified that letterhead date is date of final review determination. IPRO file review findings: 16 of the 20 appeal resolution notification letters did not include the required information regarding continuation of benefits and member liability for costs. At on-site interview, the plan discussed plans to look at these letters and add the necessary language as appropriate.	

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**
	be held liable for the cost of those benefits if the hearing decision 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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	member's life or health or ability to attain, maintain, or regain 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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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,	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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 member's request will be deemed to have been approved as 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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
13.8.6	Format of Resolution Notice - In addition to written notice, the CCN must also make reasonable effort to provide oral notice.	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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	**Continuation of Benefits**			
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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 appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached. A State Fair Hearing Officer issues a hearing decision adverse to the member. The time period or service limits of a previously authorized service has been met.			
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Full	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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**
	procedure without the prior written approval of DHH.			
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	
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	Contract language in 4.1.1.1 – Grievance System Grievance, Appeal & SFH P&P (124.12.008).	

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	QAPI Program Description – IV Purpose (p8) Quality Improvement Evaluation PIP reports Performance Measure reports Based on a review of the above and other quality program documents, it is evident that LaCare objectively and systematically monitors and evaluates the quality and appropriateness of care and services. Since most measurements are in the baseline phase, it is too soon to assess for improved patient outcomes.	
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	Addressed in QAPI Program Description VII Program Scope, 2012 – 2013 PIP reports, Medical Record Audit reports of provider compliance with documentation requirements, Performance Measure reports - CY 2012 data, CAHPS Medicaid Adult, Child, CCC survey reports and Provider Satisfaction Survey report.	
14.1.1.3	Detect underutilization and overutilization of services	Full	Addressed in QAPI Program Description VI Objectives, Emergency Room Utilization PIP report, HEDIS Access to Care measures CY 2102 data, and PCP Profile reports to DHH. LaCare indicated that the plan intends to create and distribute provider profile reports to its network PCPs. The reports will include quality and utilization measures. A template has been developed.	
14.1.1.4	Assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Full	Addressed in QAPI Program Description VI Objectives and QAPI Program Description IX B Regional Provider Councils. LaCare indicated that the plan assesses quality of care	

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 members with special health care needs (SHCN) via its ICM programs for members with cardiovascular conditions, sickle cell disease and diabetes. The plan's blended care management program addresses gaps in care, transportation needs, assists in scheduling PCP appointments, and conducts strategic follow up of members. Member satisfaction is assessed for all ICM participants. It was suggested that LaCare consider stratifying its rates for HEDIS measures by category of eligibility (e.g., SSI, Foster children) to identify and intervene for possible disparities in care.	
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 evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	Full	Addressed in QAPI Program Description VI Objectives. Per DHH guidelines, LaCare has initiated PIPs focused on Emergency Department (ED) utilization and Cervical 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	Addressed in QAPI Program Description and Quality Management Evaluation 2012.	
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	Full	The LaCare Board of Directors (BOD) delegates this	

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**
	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.		responsibility to the plan's Executive Director and the QAPI Committee (QAPIC). Evidence of BOD approval of the QAPI Program Description and Work Plan provided. Evidence of BOD approval of the QAPI Evaluation was requested. LaCare provided an excerpt from the BOD meeting minutes.	
14.2	**QAPI Committee**			
14.2.1	The CCN shall form a QAPI Committee that shall, at a minimum include: QAPI Committee Members	Full	Addressed in QAPI Program Description IX QAPI Committee Structure, QAPIC meeting minutes and QAPI Evaluation 2012 - QAPIC attendance matrix.	
14.2.1.1	The CCN Medical Director must serve as either the chairman or co-chairman;	Substantial	QAPI Program Description IX QAPI Committee Structure indicates that the Executive Director is chair while the QAPIC charter states the Medical Director is the committee chair. The Quality of Clinical Care Committee was established in early 2013 including external providers, provider councils, (prior was QAPIC). Meeting minutes demonstrate that the Medical Director acts as committee chair and facilitator at the meetings. The plan indicated that the Executive Director and Medical Director co-chair the committee. The documents will be reconciled and corrected. In 2013, the plan revised its committee structure and established the QCCC of which external providers via the provider councils are members. Per the QAPI Program Description, the Medical Director also chairs the Regional Provider Committee, the Quality of Clinical Care Committee, and the Credentialing Committee.	

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**
14.2.1.2	Appropriate CCN staff representing the various departments of the organization will have membership on the committee; and	Full	Addressed in QAPI Program Description IX QAPI Committee Structure. Members include: the Executive Director, Medical Director and representatives from all departments, including: Appeals, Credentialing, Medical Economics, ICM, Operations, Provider Network Management, Quality, Utilization Management, and Compliance. This was verified in the meeting minutes. The attendance roster and the QAPI Evaluation evidenced low participation/member attendance at meetings. The plan indicated new members were invited to replace those who did not attend meetings and that improvement has been seen in 2013.	
14.2.1.3	The CCN is encouraged to include a member advocate representative on the QAPI Committee.	Minimal	The QAPI Program Description did not indicate that a Member Advocate representative is a member of the QAPIC. The QAPIC Charter states that a Member Advocate(s) will be a member. Attendance of a Member Advocate representative was not seen in the 2012 or 2013 QAPIC minutes.	MCO response: The contract encourages the CCN to include a member advocate on the QAPI Committee; however, this is not a requirement. Although ACLA was unable to secure a member advocate representative for QAPI, this is not a requirement requiring corrective action. IPRO response: No change in determination. Since the contract requirement states that the plan is "encouraged to include a member" and that the QAPIC Charter states that a member will be included, the plan should document its strategy to solicit member participation. Barriers to member participation should be identified and attempts to resolve them should be documented.
14.2.2	QAPI Committee Responsibilities	N/A		
14.2.2.1	The committee shall meet on a quarterly basis;	Full	QAPI Program Description IX A – QAPI Committee indicates that the committee shall have quarterly meetings. Meeting minutes demonstrated that the committee exceeded the requirement, with 5 meetings in 2012: January, March, May, July, and Sept.	

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**
14.2.2.2	Direct and review quality improvement (QI) activities;	Full	Addressed in QAPI Program Description VIII Program Structure and QAPI Program Description IX A QAPI Committee. Evidence of this was seen in the meeting minutes.	
14.2.2.3	Assure than QAPI activities are implemented throughout the CCN;	Full	Addressed in QAPI Program Description IX A QAPI Committee and X J Additional Resources. Evidence was seen in the meeting minutes.	
14.2.2.4	Review and suggest new and or improved QI activities;	Full	Addressed in QAPI PD IX A QAPI Committee. Evidence was seen in the meeting minutes.	
14.2.2.5	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	Full	Addressed in QAPI Program Description D IX A QAPI Committee. Evidence was seen in the meeting minutes.	
14.2.2.6	Designate evaluation and study design procedures;	Full	Addressed in QAPI PD IX A QAPI Committee. Evidence was seen in meeting minutes.	
14.2.2.7	Conduct individual PCP and PCP practice quality performance measure profiling;	Full	Addressed in QAPI Program Description IX A QAPI Committee and IX D QCCC. Per DHH requirements, LaCare submits provider profile reports monthly. According to the plan, these are for DHH and LaCare internal use only. Providers do receive ED utilization reports with follow up by account executives. As noted previously, LaCare is developing a quality and utilization provider profile report for distribution.	
14.2.2.8	Report findings to appropriate executive authority, staff, and departments within the CCN;	Substantial	Per QAPI Program Description IX A QAPI Committee, information is disseminated from the QAPIC to plan staff and departments via the department heads who are QAPIC members and bring information back to their staff members. Evidence of the QAPIC reporting to the Board 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**
			Directors was not evident in the documents provided.	
14.2.2.9	Direct and analyze periodic reviews of members' service utilization patterns;	Full	Addressed in QAPI Program Description IX A QAPI Committee and QAPI Work Plan A3, E9. Evidence was seen in meeting 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	Addressed in QAPI PD IX A QAPI Committee. Meeting minutes were provided. LaCare provided a copy of an e-mail message to DHH that showed submission of the required documents.	
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	Addressed in QAPI Program Description XB Director, Quality Management and QAPI Program Evaluation 2012. LaCare provided a copy of an e-mail message to DHH that showed submission of the QAPI Evaluation 2012.	
14.2.2.12	Ensure that a QAPI committee designee attends DHH Quality Committee meetings.	Full	Per the QAPIC Charter, the Medical Director or designee is to attend the DHH Quality Committee meetings. LaCare provided a copy of the DHH meeting minutes. The LaCare Medical Director was noted as an attendee.	
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	Addressed in QAPI Work Plan Approval of the QAPI Program Description and QAPI Work Plan by the BOD was requested. LaCare provided an excerpt from the BOD meeting minutes. Per LaCare, this was submitted to DHH prior to the readiness review.	
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making,	Full	QAPI Work Plan - Notations regarding the Activity, Responsible party, and Timeline addresses requirement.	

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**
	intervention and assessment of results;			
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	Full	Addressed in QAPI Work Plan – Activity and QAPI Evaluation 2012.	
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	Substantial	The QAPI Work Plan delineates the Responsible Department/Staff, and assignment of the activity Lead Role and Support Role. Training of the staff assigned was not evidenced in the Work Plan or in the QAPI Program Description. LaCare indicated that this would be added to the QAPI Program Description.	
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program.	Full	Addressed in QAPI PD IX B Regional Provider Councils, QAPI PD IX A QAPIC – 6 practitioner voting members and QAPI PD IX D QCC – 2 - 4 practitioner voting members. Recommendations from the Regional Provider Councils were noted in the QAPIC meeting minutes.	
14.2.4	QAPI Reporting Requirements: 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.	Full	Annual QAPI Evaluation contained new/improved activities and an overall evaluation of QAPI program effectiveness.	
14.3	**Performance Measures**			
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	Full	Reports of clinical and administrative Performance Measures for CY 2012 data provided.	

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**
	of the CCN Quality Companion Guide.			
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	Reports of clinical and administrative Performance Measures for CY 2012 data provided. Some HEDIS® measures (e.g., Use of Appropriate Medications for People with Asthma, Management of ADHD Medication, Well Child Visits 15 months) could not be reported as LaCare members did not meet the HEDIS® continuous enrollment criteria. In addition, some measure denominators were very small (< 30) due to the number of members meeting the continuous enrollment criteria. CAHPS Medicaid Adult, Child, CCC reports provided. Per LaCare, The specifications for the AHRQ and CHIPRA measures are being clarified as they relate to the Louisiana Medicaid CCN population and will be reported in the future. LaCare indicated that the Adolescent Well Care Visits measure was one of the priorities for improvement. This measure is particularly challenging to address. Interventions include: reminder mailings, sound bites, member incentives (a Subway gift card), community outreach. The plan was asked about the use of school-based clinics and whether they might obtain visit records from these clinics to supplement their own data. LaCare indicated that the plan is currently working to develop a partnership with the school based clinics. LaCare reported that another focus for improvement is use of controller medications for asthma. An improvement in outcomes was seen as follows: August 2012 0.01% (administrative data only); August 2013 24% (administrative data only).	

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 indicated that improvement has also been seen in the measure rates for the CMS EPSDT report. More visits and more services are reported overall.	
14.3.1.2	The CCN shall have processes in place to monitor and self-report all performance measures.	Full	Addressed in QAPI Work Plan, QAPI Program Description and Performance Measure reports CY 2012 data.	
14.3.1.3	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	Full	Addressed in Performance Measure reports CY 2012 data.	
14.3.1.4	Administrative PMs shall be submitted to DHH semi-annually and upon DHH request.	Full	Administrative Performance Measure reports address this requirement.	
14.3.1.5	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	Full	LaCare has disseminated Clinical Practice Guidelines for Asthma, Chronic Obstructive Pulmonary Disease and Diabetes Mellitus. These are shared with providers via the Provider Network Representatives during onsite visits. Evidence of assessment of provider compliance with guidelines was requested. LaCare indicated that this is assessed with the medical record audit and that the Clinical Performance Measures measure the network compliance with clinical guidelines for preventive care, diabetes, COPD, and hypertension. LaCare also investigates and tracks Quality of Care issues via peer review. Since LaCare has just reported its first year of measurement data, it is too soon to assess for improvement.	
14.3.2	Incentive Based Performance Measures	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**
14.3.2.1	Incentive Based (IB) measures are Level I measures that may affect PMPM payments and can be identified in Appendix J annotated with "$".	N/A	N/A – Contract provision	
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	N/A – Contract provision	
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 DHH will provide sixty (60) days notice of such change.	N/A	N/A – Contract provision	
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	Full	As noted previously, LaCare provided the DHH reports for the clinical and administrative performance measures.	

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**
	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.			
14.3.3.2	DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.	N/A	N/A – Contract provision	
14.3.4	Performance Measure Goals	N/A		
14.3.4.1	The Department will establish benchmarks for Incentive Based and Level I Performance measures utilizing statewide data of the Medicaid Fee for Service Population for CY 2011 with the expectation that performance improves by a certain percentage.	N/A	N/A – DHH responsibility The Level 1 measures include Adults Access to Ambulatory Providers, Comprehensive Diabetes Care: HbA1c Testing, Chlamydia Screening for Women, Well Child Visits Ages 3, 4, 5, and 6 Years, Adolescent Well Care Visits. The current benchmarks are based on CY 2011 Medicaid Fee For Service rates.	
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	N/A – DHH responsibility (for 2015)	
14.3.5	Performance Measure Reporting	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
14.3.5.1	The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Full	Performance Measure reports for CY 2012 data addresses this requirement.	
14.3.5.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.	Full	Performance Measure reports for CY 2012 data addresses this requirement. LaCare provides reports for the measures and data required by DHH in the DHH specified format.	
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	Addressed in QAPI Program Description and Performance Measure reports for CY 2012 data. LaCare provides reports for the measures and data required by DHH in the DHH specified format.	
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	Provider Profile reports to DHH address requirement.	
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	N/A – DHH responsibility	
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	The plan has just provided the first annual reports for the performance measures. Validation of the measures by DHH/designee is pending.	
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	Full	Cooperation with the EQRO was evidenced in submission of the required Annual Compliance Review data and information and PIPs.	

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**
	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.			
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 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.	N/A	A Corrective Action Plan is not applicable at this time as the first review is in progress. LaCare indicated that there were no CAPs related to the Readiness Review.	
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	The first annual Performance Measure rates have recently been reported, the benchmarks are the FFS CY 2011 rates. No CAP is required.	
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	LaCare indicated there was a prior CAP related to encounter data submission of pharmacy data and this has since been closed.	
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	N/A	N/A – no CAP at present	

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**
	resubmit, within fourteen (14) calendar days, a new CAP that addresses the deficiencies identified by DHH.			
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		
14.3.7.4	DHH may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	N/A	N/A – contract provision	
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	The 2012 – 2013 PIPs directed by DHH and/or chosen by LaCare include: Emergency Department Utilization Cervical Cancer Screening. LaCare indicated that PIP topics also include: Adult Quality of Care Measures: Readmissions for Sickle Cell and Elective C-sections before 39 Weeks Gestation. These are all plan PIPs with biweekly collaborative conference calls.	
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	PIP Proposals and Interim Reports: Emergency Department Utilization Cervical Cancer Screening.	

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**
14.3.8.3	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; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	Full	PIP Proposals and Interim Reports: Emergency Department Utilization Cervical Cancer Screening. EQRO Comments and Feedback for proposals and interim reports address requirement.	
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;	Full	PIP Proposals 2012: Emergency Department Utilization and Cervical Cancer Screening were submitted by LaCare. The PIP proposal template ensures the required elements are reported.	

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**
	• 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.			
14.3.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice guidelines to objectively evaluate the care the 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	Full	The 2012 – 2013 PIPs directed by DHH and/or chosen by LaCare include: Emergency Department Utilization Cervical Cancer Screening. PIP Proposals 2012: Emergency Department Utilization and Cervical Cancer Screening were submitted by LaCare. The PIP proposal template and the EQRO comments and technical support ensure that the PIPs meet requirements.	

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**
	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; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.			
14.3.8.6	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	PIP Proposals and Interim Reports: Emergency Department Utilization Cervical Cancer Screening. Topics per DHH direction.	
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	N/A – No PIPs specified by CMS	
14.3.8.8	Each Performance Improvement Project shall be completed in a	Full	Per the interim reports and the EQRO feedback, it is evident that the 2012 PIPs are in progress 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**
	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.		proceeding per the specified timeline.	
14.3.9	PIP Reporting Requirements	N/A		
14.3.9.1	The CCN shall submit PIP outcomes annually to DHH.	Full	PIP Interim Reports: Emergency Department Utilization Cervical Cancer Screening.	
14.3.9.2	Reporting specifications are detailed in the Quality Companion Guide.	N/A	N/A – contract provision	
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	N/A – contract provision No additional PIP reporting has been requested by DHH.	
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	Addressed in CAHPS survey reports for: Adult Medicaid Child Medicaid Children with Chronic Conditions.	
14.4.2	The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys.	Full	LaCare's CAHPS vendor, Morpace, is listed as an NCQA certified survey vendor on the NCQA website.	
14.4.2.1	The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with	Full	Addressed in CAHPS survey reports from Morpace for: Adult Medicaid Child Medicaid	

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**
	Chronic Conditions survey.		Children with Chronic Conditions. LaCare indicated that the plan has in place workgroups with members and a department staff member to address CAHPS findings. A plan staff member chairs the group and quality staff will implement the recommended interventions. It was suggested that in order to investigate the root causes of satisfaction issues, LaCare might consider conducting member focus groups and/or member interviews.	
14.4.3	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	Full	As certified vendor, Morpace conducts the CAHPS surveys in accordance with the required methodology as delineated in the HEDIS Volume 3: Specifications for Survey Measures. The methodology is summarized in the reports. The survey sample frame is validated by the plan's HEDIS audit organization.	
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	CAHPS survey reports for: Adult Medicaid Child Medicaid Children with Chronic Conditions. A statistically valid sample size for the CAHPS surveys is assured by the certified vendor, Morpace. Reporting of results by GSA was not required of MCOs.	
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.	Full	Statistical analysis and benchmarking are performed by the NCQA- certified vendor, Morpace.	
14.4.7	The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used	Full	Per the CAHPS survey analysis of the results indicate that the survey version used for the Adult Medicaid Child Medicaid and Children with Chronic Conditions	

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**
	and include:		surveys was the CAHPS Health Plan Surveys version 5.0 for Medicaid, the most recent version.	
14.4.7.1	Getting Needed Care	Full	Addressed in CAHPS survey reports for: Adult Medicaid, Child Medicaid, and Children with Chronic Conditions.	
14.4.7.2	Getting Care Quickly	Full	Addressed in CAHPS survey reports for: Adult Medicaid, Child Medicaid, and Children with Chronic Conditions.	
14.4.7.3	How Well Doctors Communicate	Full	Addressed in CAHPS survey reports for: Adult Medicaid, Child Medicaid, and Children with Chronic Conditions.	
14.4.7.4	Health Plan Customer Service	Full	Addressed in CAHPS survey reports for: Adult Medicaid, Child Medicaid, and Children with Chronic Conditions.	
14.4.7.5	Global Ratings	Full	Addressed in CAHPS survey reports for: Adult Medicaid, Child Medicaid, and Children with Chronic Conditions.	
14.4.8	Member Satisfaction Survey Reports are due 120 days after the end of the plan year.	N/A		
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	Provider Satisfaction Survey Report provided. LaCare conducted its first annual Provider Satisfaction Survey. The report addresses the required elements: o Provider enrollment o Provider communication o Provider complaints o Claims processing o Claims reimbursement o Utilization Management process: medical reviews Assessment of satisfaction with PCMH implementation support was not found. The plan was asked which provider satisfaction issues were identified, which were determined priorities, and what types of initiatives and how addressed. LaCare indicated that a workgroup was convened 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**
			information would be provided. The information has not been received.	
14.5.1.1	The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	Full	LaCare indicated a copy of the Provider Satisfaction survey tool and methodology was submitted to DHH prior to administration. DHH approved the survey tool and methodology.	
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	Provider Satisfaction Survey report provided.	
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	DHH responsibility	
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	According to LaCare, no CAPs related to quality performance are required.	
14.6.3	Upon any indication that the CCN's quality performance is not	N/A	No enrollment restrictions in place.	

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**
	acceptable, DHH may restrict the CCN's enrollment activities including, but not limited to, termination of automatic assignments.			
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	No enrollment restrictions in place.	
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	LaCare has cooperated with the EQRO's Annual Compliance Review requirements.	
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	LaCare has provided all requested information and data to the EQRO regarding quality and access.	
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	LaCare has cooperated with the EQR review activities.	
14.7.3	If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN in accordance with the	N/A	No enrollment restrictions in place.	

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**
	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 first EQR Annual Technical Report has not yet been produced. Therefore, there are no recommendations for improvement at this time.	
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	LaCare has applied for NCQA Interim Health Plan Accreditation. The accreditation survey activities are in process. The desk top review documentation is due October 15, 2013.	
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	Accreditation application submitted timely. Evidence of submission of copies of all accreditation application communications and correspondence to DHH was requested. LaCare provided email communications.	
14.8.3	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA	N/A	N/A – The accreditation survey is currently in process and the result is pending.	

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**
	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	Addressed in Credentialing and Re-Credentialing Policies and Procedures. The policies and procedures were submitted and approved as part of the Readiness Review. Determination of compliance with NCQA standards is pending as the Accreditation Survey is in process.	
14.9.1.1	The CCN shall use the state's standardized credentialing form (see Appendix F – Louisiana Standardized Credentialing Application Form).	Full	The use of the Louisiana Standardized Credentialing Application Form was verified via the file review.	
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 submitted as part of the Proposal, when a change is made, and annually thereafter.	Full	LaCare submitted its Credentialing and Re-Credentialing policies and procedures as part of its proposal and Readiness Review.	
14.9.2	The process for periodic re-credentialing shall be implemented at least once every three (3) years.	Full	Credentialing and Re-Credentialing Policies and Procedures provided.	

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**
			Only initial credentialing reviews have been conducted to date.	
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.	Minimal (Based on submission of additional contracts, determination is changed to "Full"	Delegate contracts were reviewed for description of credentialing activities and requirements for credentialing by DHH standards. The following vendors have responsibility for delegated credentialing and findings were: Contract provisions in place: DentaQuest VSP FMOL LSU Ochsner. Contracts were not provided for: Health Services of NL South Louisiana Medical Associates St Jude Research Hospital Tulane Medical Center Take Care Health Willis-Knighton Health System Oversight of delegates, for credentialing specifically, is evidenced in the QAPI Evaluation 2012.	MCO response: Delegated credentialing contracts are attached for HSNL, SLMA, St. Jude, Tulane, Take Care, and Willis Knighton. IPRO response: Contracts were reviewed for the delegates noted. Determination changed to "Full."
14.9.4	If the CCN has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	N/A	This does not apply as LaCare is not yet NCQA-accredited. The plan is pursuing NCQA accreditation. The Desk Top Review is scheduled for October 2013.	
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	Full	Credentialing and Re-credentialing Policies and Procedures and Provider Termination and Ongoing Monitoring Policies and Procedures address requirement. Encouragement of board certification for network providers was found in the credentialing and re-credentialing policy.	

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**
	of applicable board certification.		Evidence of implementation of policies and procedures addressed in QAPI Evaluation 2012 – report of providers/practices/organizations credentialed/added to the plan provider network and Credentialing file reviews.	
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.	Full	Provider Suspension/Sanction Policies and Procedures address requirement. LaCare indicated that the mechanism for reporting quality deficiencies that result in termination or suspension of providers and/or subcontractors was submitted to DHH as part of the Readiness Review. Implementation of mechanism for reporting quality deficiencies was seen in the QAPI Evaluation 2012, which included a summary of the QOC incidents and outcomes for the CY 2012.	
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.	Full	Addressed in Work Flow for Provider and Member Inquiries and Policies and Procedures for Informal Provider Dispute and Formal Provider Dispute. LaCare indicated that the provider dispute and appeal process was submitted to DHH as part of the Readiness Review. Implementation of provider dispute and appeal process was demonstrated in the file review.	
14.10	**Member Advisory Council**			
14.10.1	The CCN shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow	Full	Addressed in Member Advisory Committee Charter, MAC Training materials, and MAC meeting agendas and minutes.	

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**
	participation in providing input on policy and programs.			
14.10.2	The Council is to be chaired by the CCN's Administrator/CEO/COO or designee and will meet at least quarterly.	Full	Addressed in MAC Charter and MAC meeting agendas and minutes. MAC meeting agendas and minutes demonstrated that the committee met as required.	
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	Participation by members/significant others, and/or advocates was demonstrated in the MAC meeting minutes.	
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	Addressed in MAC Training presentation and guide, and MAC meeting minutes.	
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	Addressed in MAC Charter. LaCare indicated that the MAC Plan was submitted to DHH for the Readiness Review and that the annual reports deadline was extended from Dec 15, 2012 to Feb 2013.	
14.10.6	DHH shall be included in all correspondence to the Council, including agenda and Council	Full	Evidence that all correspondence to the MAC is provided to DHH, including MAC agendas, minutes, was requested. LaCare provided a copy of the Outlook	

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**
	minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.		invitations to the DHH representative. Evidence that the plan posts the MAC agendas ad minutes to its website was requested. LaCare provided a screen shot of its website page.	

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	Full	The plan submitted P/P AML-001 (Statutory Reporting Process AmeriHealth Caritas Louisiana), which documents general processes utilized by Statutory Reporting and the AmeriHealth Caritas Louisiana Compliance Coordinator to ensure timely and accurate compliance with all reporting requirements and resolution of related issues on a timely basis and to ensure adherence with Federal and State HIP AA privacy regulations. During the interview, the plan explained that their Philadelphia office coordinates all federal and state reporting for Amerihealth state offices. For each state, there is a Report Submission Schedule that is followed and each department that is responsible for a report is alerted in advance of upcoming reporting deadlines. Reports submitted to DHH were provided in the relevant review areas during the compliance 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**
	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 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.			