Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.0	**Provider Network**			
6.0.1	The CCN must provide a comprehensive primary care network to ensure its membership has access at least equal to, or better than community norms.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.0.2	Services shall be accessible to CCN members in terms of timeliness, amount, duration and scope as those are available to Medicaid recipients within the same GSA who are not enrolled in the CCN Program.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.0.3	The CCN is encouraged to have available non-emergent after-hours physician or primary care services within its network.	Full	Addressed in Network Development and Management Plan 11.16.11	
6.0.4	If the network is unable to provide medically necessary services required under Contract, the CCN shall ensure timely and adequate coverage of these services through an out-of-network provider until a network provider is contracted.	Full	Addressed in Network Development and Management Plan 11.16.11	
6.0.5	The CCN is responsible for covering services related to the following: the prevention, diagnosis, and treatment of health impairments; the ability to achieve age-appropriate growth and development; and the ability to	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook 5.11.11	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	attain, maintain, or regain functional capacity.			
6.0.6	The CCN is expected to design a network that provides a geographically convenient flow of patients among network providers. The provider network shall be designed to reflect the needs and service requirements of the CCN's member population.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.0.7	There shall be sufficient personnel for the provision of all enhanced primary care case management services.	Full	Addressed in Network Development and Management Plan 11.16.11; Network Development and Management Plan Annual Report Final; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.1	**Significant Traditional Providers**			
6.1.1	The CCN shall make a good faith effort to include in its network significant traditional providers (STPs) in its GSA for the first two (2) years of operation under the CCN Contract; provided the STP agrees to participate as an in-network provider and abide by the provisions of the provider subcontract with the CCN.	Full	Addressed in Network Development and Management Plan 11.16.11. Statement regarding STPs is included; however, does not emphasize "first two years of operation."	
6.1.2	In the event an agreement cannot be reached and an entity does not participate in the CCN, the CCN shall maintain documentation detailing efforts which were made.	Full	Addressed in Network Development and Management Plan 11.16.11	
6.1.3	This requirement does not prohibit the CCN from limiting provider participation to the extent	Full	Addressed in Network Development and Management Plan 11.16.11	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	necessary to meet the needs of the CCN members. This requirement does not interfere with measures established by the CCN to control costs and quality consistent with its responsibilities under this contract.			
6.2	**Network Provider Development and Management Plan**			
6.2.0.1	The CCN shall develop and maintain a Primary Care Network Provider Development and Management Plan which ensures access to primary care services and PCP case management services.	Full	Addressed in Network Development and Management Plan 11.16.11. Although the term "PCP case management" is not included in the plan, the plan addresses the use of a Specialist as a PCP for members with chronic conditions.	
6.2.0.2	The Network Development and Management Plan shall be evaluated, updated annually and submitted to DHH within thirty (30) days from the date the Contract with DHH is signed by the CCN and annually thereafter. The submission of the Network Management and Development Plan to DHH is an assurance of the adequacy and sufficiency of the CCN's primary care provider network.	Full	Addressed in Network Development and Management Plan 11.16.11; Network Development and Management Plan Annual Report Final	
6.2.0.3	The CCN shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services.	Full	Plan Onsite Interview Response: No major changes have happened. In the event of a significant change in operations, the plan would notify DHH within 24 hours and all members would be notified by letter within 15 days. If termination known ahead of time, notification would be sent within 30 days. Leadership would analyze population affected and make immediate plans for continuation of care.	
6.2.0.4	In accordance with the requirements in this RFP, and the	Full	Addressed in Network Development and Management Plan 11.16.11	

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' needs, the proposed network shall be sufficient to provide core benefits and services within designated time and distance limits. The Network Provider Development and Management Plan shall identify gaps in the CCN's provider network and describe the process by which the CCN shall assure all covered services are delivered to CCN members. Planned interventions to be taken to resolve such gaps shall also be included.			
6.2.0.5	The CCN must maintain and monitor a primary care provider network that is supported by written agreements and is sufficient to meet the minimum capacity requirements set forth in this RFP. When designing this network, the CCN must take into consideration all the requirements specified in this RFP's terms and conditions. This includes access standards and guidelines for delivery of primary care services.	Full	Addressed in Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13; and Physician, Health Care Professional, Facility and Ancillary Handbook Onsite Interview Plan Response: confirmed executed contracts for all PCPs.	
6.2.1	The CCN shall provide GEO mapping and coding of all PCPs by provider type by the deadline date specified in the Schedule of Events to geographically demonstrate capacity. The CCN shall provide updated GEO coding to DHH quarterly, or upon material change or upon request.	Full	Addressed in Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.2.2	The CCN shall develop and	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**
	implement Network Development and Management policies and policies detailing how the CCN will:			
6.2.2.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	Full	Addressed in Network Development and Management Plan 11.16.11	
6.2.2.2	Monitor network compliance with policies and rules of DHH and the CCN, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	Full	Addressed in Network Development and Management Plan 11.16.11	
6.2.2.3	Evaluate the quality of services delivered by the network;	Full	Addressed in Network Development and Management Plan 11.16.11	
6.2.2.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	Full	Addressed in Network Development and Management Plan 11.16.11	
6.2.2.5	Monitor the adequacy, accessibility and availability of its PCP network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	Full	Addressed in Network Development and Management Plan 11.16.11; and Physician, Health Care Professional, Facility and Ancillary Handbook	
6.2.2.6	Contract with providers in a manner that incorporates quality management, utilization, office audits and provider profiling;	Full	Addressed in Addressed in Louisiana Medicaid And CHIP Program Regulatory Requirements Appendix – Provider; and Physician, Health Care Professional, Facility and Ancillary Handbook	
6.2.2.7	Provide training for its PCPs and maintain records of such training;	Full	Addressed in Network Development and Management Plan Annual Report Final	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.2.2.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	Full	Addressed in UHL_6_Provider Complaint System-v1 093011	
6.2.2.9	Ensure that provider calls are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from 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	Addressed in UHL_6_Provider Complaint System-v1 093011; however, policy does not include language regarding resolution timeframes. Resolution timeframes are clearly noted in the Physician, Health Care Professional, Facility and Ancillary Handbook. Onsite Interview Plan Response: We like to solve immediately. Cases must be closed within 3 days. This is the documented standard. Onsite Case File Review: 3 of 20 cases reviewed were non-compliant for timely resolution. Recommendation: Update Provider Complaint System P&P to include resolution timeframes.	Plan response: UHC will update its P&P to include resolution timeframes. IPRO response: Determination is unchanged. Policy will be reviewed as part of next year's audit.
6.2.3	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions and any needed revisions, shall be submitted to DHH at the end of the first year of operations and annually thereafter.	Full	Onsite Interview Plan Response: Submitted an updated Network Provider Development and Management Plan in February 2013. We assumed it was approved since we received no notification that it was not approved.	
6.2.4	CCN Network Development and Management policies shall be subject to approval by DHH, Medicaid Coordinated Care Section and shall be monitored through operational audits.	N/A	DHH action item(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**
6.3	**Manner of Service Delivery and Provision**			
6.3.0.1	In establishing and maintaining the PCP network, the CCN shall consider the following:	N/A		
6.3.0.2	The maximum Medicaid enrollment capacity;	Full	Addressed in Network Development and Management Plan 11.16.11.	
6.3.0.3	The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations enrolled in the CCN;	Full	Addressed in Utilization Profile and Risk score Analysis by PCP (reviewed on site)	
6.3.0.4	The number of network providers who are not accepting new Medicaid patients; and	Full	Addressed in Network Development and Management Plan 11.16.11	
6.3.0.5	The geographic location of providers and Medicaid members; considering distance travel time, and means of transportation ordinarily used by Medicaid members.	Full	Addressed in Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.3.0.6	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.3.0.7	The CCN shall allow female members direct access to a women's health specialist for Louisiana Medicaid State Plan services necessary to provide women's routine and preventive health care services. This is in addition to the members designated source of primary care if	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	that source is not a women's health specialist.			
6.4	**Mainstreaming**			
6.4.1	DHH considers mainstreaming of CCN members into the broader health delivery system to be important. The CCN therefore must ensure that all CCN providers accept members for treatment and that CCN providers do not intentionally segregate members in any way from other persons receiving services.	Full	Addressed in Louisiana Medicaid And CHIP Program Regulatory Requirements Appendix -Provider	
6.4.2	To ensure mainstreaming of members, the CCN shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following: Denying or not providing to a member any covered service or availability of a facility. Providing to a member any covered service which is different, or is provided in a different manner, or at as different time from that provided to other members, other public or private patients, or the public at large. Discriminatory practices with	Full	Addressed in Louisiana Medicaid And CHIP Program Regulatory Requirements Appendix -Provider	

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**
	regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.			
6.4.3	If the CCN knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than the Contract), DHH shall consider the CCN to have breached the provisions and requirements of the contract. In addition, if the CCN becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) calendar days, DHH shall consider the CCN to have breached the provisions and requirements of the Contract.	Full	Addressed in Louisiana Medicaid And CHIP Program Regulatory Requirements Appendix -Provider. Exact language is not found however the language used complies with citation requirements.	
6.5	**Primary Care Providers (PCP)**			
6.5.0.1	A PCP in the CCN must be a provider who provides or arranges for the delivery of medical services, including case management which are found to be medically necessary, are made available in a timely manner as outlined in this RFP.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.5.0.4	The CCN shall identify and report to the Enrollment Broker within seven (7) calendar days any PCP approved to provide services described within	Full	Addressed in Network Development and Management Plan 11.16.11	

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 RFP who will not accept new patients or has reached capacity.			
6.5.0.5	The PCP shall serve as the member's initial and most important point of interaction.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6	**PCP Responsibilities**			
6.6.1	The PCP responsibilities shall include, but not be limited to:	N/A		
6.6.1.1	Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.1.2	Monitoring and follow-up of care provided by other medical service providers for diagnosis and treatment;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.1.3	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.1.4	Maintaining a medical record of all services rendered by the PCP and other referral providers.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.1.5	Providing for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment for emergency medical conditions;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.1.6	Providing case management services to include, but not be	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	limited to, screening and assessment, development of a treatment plan of care to address risks and medical needs and other responsibilities as defined in the Contract;			
6.6.1.7	Prohibiting discrimination in enrollment, disenrollment, and re-enrollment, based on the recipient's health status or need for health care services.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.6.2	Examples of Acceptable PCP After-Hours Coverage: the PCP's office telephone is answered after-hours by an answering service, can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes. The PCP's office telephone is answered after normal business hours by a recording directing the member to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable. The PCP's office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.6.3	Examples of Unacceptable PCP After-Hours Coverage: the office telephone is only answered during office hours; the office telephone is answered after-hours by a recording that tells patients to leave a message; the office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and returning after-hours calls outside of 30 minutes.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook	
6.7	**Adequacy of Network Provider**			
6.7.1	The CCN shall maintain appropriate levels of primary care providers for the provision of services within the each GSA to insure that all required core benefits and services are available and accessible in a timely manner in accordance with this RFP. The CCN shall enter into contracts with a sufficient number of PCPs to ensure adequate accessibility and sustainability for members.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.7.2	The locations of primary care providers must be sufficient in terms of geographic convenience to CCN members.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13	
6.7.3	The CCN shall notify DHH immediately of any changes to the composition of its provider network that materially and/or adversely affects its ability to make available all primary care services and care management services in a timely	Full	Addressed in Network Development and Management Plan 11.16.11	

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**
	manner in accordance with this RFP.			
6.7.4	The CCN shall have procedures to address changes in its provider network that negatively affect the ability of CCN members to access services. Material changes in provider network composition that are not prior approved by DHH and/or that may impair the CCN member's access to services will be considered as grounds for sanctions, including but not limited to, termination of Contract. The CCN understands and agrees that notwithstanding the execution of this Contract, neither the CCN nor its contractor/network provider shall provide any services to a CCN member until the CCN has an adequate provider network verified and approved by DHH. Enrollees must receive written notice within thirty (30) days of any material change in provider network before the intended effective date of the change.	Full	Addressed in Network Development and Management Plan 11.16.11 Onsite Interview Plan Response: No material changes have occurred.	
6.7.7	The CCN shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers and provide verification to DHH. Failure to do so may result in monetary penalties up to $5,000 per day against the CCN.	Substantial	Addressed in Network Development and Management plan Final; however the precise frequency of the validation activities is not presented. Recommendation: Revise Network Development and Management plan to include frequency of validation activities.	MCO response: Ongoing discussions with DHH to develop a system of validation that is efficient for Providers, to avoid duplicating efforts 4 times a year for all 5 plans, have been held. When resolution is reached, UHC's Network Development and Management Plan will be updated. IPRO response: Determination is unchanged. Network Development and Management Plan 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**
6.8	**Material Change to Provider Network**			
6.8.1	All material changes in the CCN's provider network must be approved in advance by DHH, BHSF/Medicaid Coordinated Care Section.	Minimal	Addressed in Network Development and Management Plan; however it does not state that DHH must be notified in advance, it states that DHH must be notified within 24 hours of the unexpected change. Onsite Interview Plan Response: No material changes have occurred.	MCO response: UHC will revise the Plan to include a requirement that DHH be notified in advance of any known material change. IPRO response: Determination is unchanged. Network Development and Management Plan will be reviewed as part of next year's audit.
6.8.2	A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the CCN's ability to meet the performance and network standards as described in this Contract. It also includes any change that would cause more than 5% of members in the GSA to change the location where services are received or rendered.	N/A	Addressed in Network Development and Management Plan 11.16.11; however the term "material change" is not used. The plan does describe steps to assess impact of change to medically necessary services for its members. Onsite Interview Plan Response: No material changes have occurred.	
6.8.3	The CCN must submit the request for approval of a material change in their provider network, including copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Non-Compliance	Language is not presented in submitted documentation. Onsite Interview Plan Response: No material changes have occurred.	MCO response: UHC will revise the Plan to include a requirement that DHH be notified in advance of any known material change. The revision will include a requirement to submit the request for approval of a material change in the provider network, including a copy of the draft notification to affected members, sixty (60) days prior to the expected implementation of the change. IPRO response: Determination is unchanged. Network Development and Management Plan will be reviewed as part of next year's audit.
6.8.4	The request must include a description of any short-term gaps	Non-Compliance	Language is not presented in submitted documentation.	MCO response: UHC will include in its revision above (6.8.3) to include 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**
	identified as a result of the change and the alternatives that will be used to fill them.		Onsite Interview Plan Response: No material changes have occurred.	description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them. IPRO response: Determination is unchanged. Network Development and Management Plan will be reviewed as part of next year's audit.
6.8.5	If DHH does not respond within thirty (30) days the request and the notice are deemed approved.	N/A	Language is not presented in submitted documentation. Onsite Interview Plan Response: No material changes have occurred.	
6.8.6	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.	Full	Addressed in Network Development and Management Plan 11.16.11.	
6.8.7	The CCN shall notify DHH/BHSF/Medicaid Coordinated Care Section within one (1) business day of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the CCN, or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR 438.207(c)].	Full	Addressed in Network Development and Management Plan 11.16.11	
6.8.8	This notification shall include: - Information about how the provider network change will affect	Full	Addressed in Network Development and Management Plan 11.16.11; and Small Medical Group_LA _Sample with LA Medicaid.	

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 delivery of core benefits and services, and - The CCN's plans for maintaining the quality of member care, if the provider network change is likely to affect the delivery of core benefits and services. - CCNs shall give hospitals and provider groups ninety (90) days notice prior to a contract termination without cause. - Contracts between the CCN and single practitioners are exempt from this requirement.			
6.9	**Patient-Centered Medical Home**			
6.9.0.1	The CCN will promote and facilitate the capacity of all PCP practices to meet the recognition requirements of a NCQA PPC®-PCMH™ as jointly defined by NCQA or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Primary Care Home Accreditation and DHH.	Full	Addressed in Bayou Health Plan Patient Centered Medical Home (PCMH) Design and Implementation Plan 5.1.12; and Physician, Health Care Professional, Facility and Ancillary Handbook	
6.9.0.2	The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the establishment of PCP practice NCQA PPC®-PCMH™ recognition, Levels 1-3 or JACHO Primary Care Home	Full	Addressed in 058 UHC 2013 Annual/PCMH Recognition Report	

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.			
6.9.1.1	The CCN shall provide a PCMH Implementation Plan within ninety (90) days of the Go Live date that identifies the methodology for promoting and facilitating PPC®-PCMH recognition and/or JCAHO PCH accreditation.	Full	Addressed in Bayou Health Plan Patient Centered Medical Home (PCMH) Design and Implementation Plan 5.1.12	
6.9.1.2	The implementation plan shall include, but not be limited to: payment methodology for payment to primary care practices for the specific purpose of supporting necessary costs to transform and sustain NCQA PPC®- PCMH recognition or JCAHO PCH accreditation through enhanced payment or performance based incentives for achieving the necessary parameters; provision of technical support, to assist in their transformation to PPC®-PCMH recognition or JCAHO PCH accreditation(e.g., education, training, tools, and provision of data relevant to patient clinical care management); facilitation of specialty provider network access and coordination to support the PCMH; and facilitation of data interchange between PCMH practices, specialists, labs, pharmacies, and other providers.	Full	Addressed in Bayou Health Plan Patient Centered Medical Home (PCMH) Design and Implementation Plan 5.1.12	
6.9.2	The CCN shall meet or exceed the following thresholds and timetables for primary care practices to	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	achieve NCQA PPC®- PCMH recognition or JCAHO PCH accreditation:			
6.9.2.1	By the end of the first year of operations in the region: Total of 20% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited.	N/A	Addressed in 058 UHC 2013 Annual/PCMH Recognition Report. Current rate is 6.39%. DHH has extended the date for achieving the one year goal to June 2013. Final results pending at time of review.	
6.9.2.2	By the end of the second year of operation under the Contract: o Total of 30% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; and Total of 10% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited.	N/A		
6.9.2.3	By the end of the third year of operation under the Contract: o Total of 10% of practices shall be NCQA PPC®-PCMH Level 1 recognized or JCAHO PCH accredited; o Total of 40% of practices shall be NCQA PPC®-PCMH Level 2 recognized or JCAHO PCH accredited; and o Total of 10% of practices shall be NCQA PPC®-PCMH Level 3 recognized or JCAHO PCH accredited.	N/A		
6.9.3	The CCN shall submit an annual report indicating PCP practices that are NCQA PPC®-PCMH recognized,	Full	Addressed in 058 UHC 2013 Annual/PCMH Recognition Report	

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 the levels of recognition, or JCAHO PCH accreditation. Nurse practitioner-led practices may meet NCQA PPC®-PCMH Level 1 recognition requirements and notify the CCN, via attestation and supporting documentation, of the level achieved. The CCN may include these practices, and identify in reporting, the number of these practices that have met NCQA PPC®-PCMH Level 1 requirements.			
6.9.4	The CCN shall participate in Patient-Centered Primary Care Collaborative activities.	Full	Addressed in 058 UHC 2013 Annual/PCMH Recognition Report Attachments – Accountable Care Health Home Program Onsite Interview Plan Response: Collaborated with providers and community organizations, including LA Quality Forum and LA Association of Health Plans, which focus on patient centered medical homes. Monthly meeting with representative of the plans.	
6.9.5	Subsequent renewal of the Contract beyond the initial three year period will require increased percentage of PCP practices to be NCQA recognized or JCAHO accredited to a total of eighty (80%) of practices.	N/A		
6.9.6	The CCN shall report those primary care provider practices that achieve recognition or meet the requirements of the National Committee for Quality Assurance (NCQA) for PPC®-PCMH™ or JCAHO Primary Care Home Accreditation. The CCN shall ensure thresholds and timetables are met for the	Full	Addressed in 058 UHC 2013 Annual/PCMH Recognition Report	

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**
	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.			
6.10	**Local Public Health Agencies and LSU Hospital Outpatient Clinics**			
6.10.0.1	The CCN should coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues will be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the CCN.	Substantial	Addressed in Network Development and Management Plan 11.16.11; however examples of signed policy memos or separate memorandums of understanding were not presented.	MCO response: UHC will obtain signed memos after coordination with OPH and BHSF. IPRO response: Determination is unchanged. Process will be reviewed as part of next year's audit.
6.10.0.2	The CCN shall offer a Contract to all LSU Health Services Science Center hospital outpatient clinics that meet the criteria to become a primary care provider and may require LSU to meet the same terms and conditions as other primary care providers.	Full	Addressed in Network Development and Management Plan 11.16.11	
6.11	**Federal Quality Health Centers (FQHC)/Rural Health Clinics (RHC) Contracting Requirements**			
6.11.1	The CCN shall offer a Contract to all Federally Qualified Health Centers and, where applicable, Rural Health Clinics (free standing and hospital-based) in its GSA.	Full	Addressed in Network Development and Management Plan Final	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.11.1.1	If an agreement cannot be reached with a FQHC/RHC, the CCN shall inform DHH and the CCN is not required to provide access to primary care services provided by the FQHC/RHC except in the following cases: the medically necessary services are required to treat an emergency medical condition; or FQHC/RHC services are not available through CCNs (CCN-P or CCN-S) in the geographic service area within DHH's established time and distance travel standards.	Full	Addressed in Member Handbook; however exact language not used. Member Handbook states, "Use any hospital or other facility for emergency care". Also addressed in Network Development and Management Plan, in which plan states, "We are proud to announce that we have contracted with 95% of all existing FQHC's and RHC's and are in active negotiations with the remaining 5% to reach our goal of contracting with 100% of these entities vital to the population we serve."	
6.11.2	The CCN must explicitly identify and inform potential enrollees and members the availability on FQHC/RHC services and limitation on access to those services. The CCN shall inform members of this right in their member handbooks.	Full	Addressed in UnitedHealthcare Community Plan Member Handbook	
6.11.3	The CCN shall have written procedures for promptly transferring medical information needed for coordinating care with a FQHC. CCNs shall expect a sharing of information and data and appropriate CCN referrals from non-network FQHCs.	Full	Addressed in Network Development and Management Plan	
6.12	**School Based Health Clinics (SBHC)**			
6.12.1	SBHC (certified by the DHH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.	N/A		

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.12.2	The CCN must make a good faith effort to collaborate with SBHCs in their GSAs. The CCN may stipulate that the SBHC follow all of the CCN's required policies and procedures.	Full	Addressed in Network Development and Management Plan 11.16.11 Onsite Interview Plan Response: Most of the school based health centers are not opened all year round. Contract requirements state providers should be open all year round. We are in discussion with East Baton Rouge Parish School Based Clinics – 3 clinics will be open year round this year. One school has a free standing clinic so you do not have to attend the school to be seen at the clinic. This school will partner with the plan around adolescent screening and Chlamydia screening. If pilots are successful, the plan will reach out to the rest of state. From a quality perspective, the plan will reach out to clinics to educate on Chlamydia screening.	
6.12.3	For those SBHCs that meet the criteria to become a primary care provider the CCN must offer a Contract and may require the SBHC to meet the same terms and conditions as other primary care providers.	Full	Onsite Interview Plan Response: Contract not yet executed with the identified SBHC. Intend to use same contract used with PCPs.	
6.13	**Subcontracting Requirements**			
6.13.0.1	The CCN shall provide enhanced primary care case management services specified in this RFP. The CCN may provide these services directly or may enter into subcontracts with entities that will authorize specified Medicaid State Plan services and provide care management to the members. The provision of Medicaid State Plan services will be delivered by the Louisiana Medicaid FFS provider	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider; and Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	network. Claims will be pre-processed by the CCN and paid by the State's FI. The CCN is ultimately responsible for all requirements of the Contract, including those performed by the CCN subcontractor(s).			
6.13.0.2	Any plan to delegate enhanced primary care management responsibilities of the CCN to a subcontractor shall be approved by DHH. Model subcontracts for care management providers shall be submitted within thirty (30) days after the Contract is signed by the CCN.	N/A	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.0.3	After the execution of the Contract, the CCN shall submit to DHH for review and approval, prior to execution of the subcontract, any subcontract that is materially different from the model contract already approved by DHH for care management providers. DHH shall have the right to review and approve any and all subcontracts entered into for the provision of any activities under this RFP. The turnaround time for approval is expected to be thirty (30) days or less. Notification of amendments or changes to any contract which materially affects the subcontract, shall be provided to DHH prior to the execution of the amendment.	N/A		
6.13.0.4	The CCN shall not execute	Full	Addressed in Simplified Physician Provider (Individual)	

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 with providers who have been excluded from participation in the Medicare and/or Medicaid program or who are otherwise barred from participation in the Medicaid and/or Medicare program. The CCN shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.		Agreement.	
6.13.1	Required Terms and Conditions for Subcontracts - All subcontracts executed by the CCN pursuant to this section shall, at a minimum, include the following terms and conditions and no other terms and conditions agreed to by the CCN and its subcontractor shall negate or supersede the requirements in this RFP:	N/A		
6.13.1.1	Contain language that the subcontractor shall adhere to all requirements set forth for CCN subcontractors in the Contract between DHH and CCN and department issued Guides; and either physically incorporating these document as appendices to the subcontract or include language in the subcontract that the CCN shall furnish these documents to the	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	provider upon request.			
6.13.1.2	Include a signature page which contains a CCN and provider name which are typed or legibly written, provider company with titles, and dated signature of all appropriate parties; (applicable for renewals as well). All subcontracts must be in writing and signed by the CCN and subcontractor.	Full	Addressed in Simplified Physician Provider (Individual) Agreement.	
6.13.1.3	Specify the effective dates of the subcontract agreement.	Full	Addressed in Simplified Physician Provider (Individual) Agreement.	
6.13.1.4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties, however the CCN may provide amendments by written notification through the CCN bulletin board, if mutually agreed to in terms of the subcontract and with prior notice to DHH.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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

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 void and all other provisions shall remain in full force and effect.			
6.13.1.10	Identify the population covered by the subcontract.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.12	Specify that the subcontractor may not refuse to provide medically necessary or core preventive benefits and services to CCN members specified under the Contract between DHH and the CCN for non-medical reasons (except those services allowable under federal law for religious or moral objections).	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.13	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.13.1.14	Specify the amount, duration and scope of core benefits and services as specified in the Louisiana Medicaid State Plan that are provided by the subcontractor, including all specific requirements outlined in the RFP and department issued Guides.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider; and Simplified Physician_Provider (Individual) Agreement.	
6.13.1.15	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.16	Specify that the provider may not refuse to provide covered medically necessary or covered preventative services to members for non-medical reasons. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.17	Include a provision which states the subcontractor is not permitted to encourage or suggest, in any way, that members be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.18	Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to CCN members	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the Contract between DHH and the CCN). CCN members and their representatives shall be given access to and can request copies of the members' medical records, and subject to reasonable charges.			
6.13.1.19	Include medical record requirements as specified in the Contract between DHH and the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.20	Require that any and all member records including but not limited to administrative, financial, and medical be retained (whether electronic or paper) for a period of six (6) years after the last payment was made for services provided to a member and retained further if the records are under review, audit, or related to any matter in litigation until the review, audit, or litigation is complete. The exception to this requirement shall include records pertaining to once-in-a-lifetime events such as but not limited to appendectomy and amputations etc.) which must be retained indefinitely and may not be destroyed. This requirement pertains to the retention of records for Medicaid purposes only; other	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	state or federal rules may require longer retention periods. Current State law (La. R.S. 40:1299.96) requires physicians to retain their records for at least six (6) years. These minimum record keeping periods commence from the last date of treatment. After these minimum recordkeeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of an authorized representative of DHH.			
6.13.1.21	Provide that DHH, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Legislative Auditor's Office, and the Louisiana Attorney General's Office shall have the right to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the Contract between DHH and the CCN, including quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted to the CCN. Such evaluation, when performed, shall be performed with the cooperation of the CCN. Upon request, the CCN shall assist in such reviews.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.13.1.22	Require the subcontractor comply and submit to the CCN disclosure of information.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.23	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the CCN and/or DHH or its designee.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.24	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the CCN/subcontractor practices and/or the standards established by DHH or its designee.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.25	Require that the subcontractor comply with any corrective action plan initiated by the CCN and/or required by DHH.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.26	Specify any monetary penalties, sanctions or reductions in payment that the CCN may assess on the provider for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a provider's failure or refusal to	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	respond to the CCN's request for information, the request to provide medical records, credentialing information, etc.; at the CCN's discretion or a directive by DHH, the CCN shall impose at a minimum, financial consequences against the provider as appropriate.			
6.13.1.27	Provide for submission of all reports and clinical information required by the CCN for reporting purposes such as HEDIS, AHRQ, and EPSDT.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.28	Require safeguarding of information about CCN members according to applicable state and federal laws and regulations and as described in Contract between DHH and the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.29	Provide the name and address of the official payee to whom payment shall be made.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.30	Make full disclosure of the method and amount of compensation or other consideration to be received from the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.31	Provide for prompt submission of complete and accurate claims information needed to make payment.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.32	Provide that subcontractors must submit all clean claims for payment no later than twelve (12) months from the date of service.	Full	Addressed in Simplified Physician Provider (Individual) Agreement. States providers must submit claims within 90 days of the date of service.	
6.13.1.33	Specify that at all times during the	Full	Addressed in Louisiana Medicaid and CHIP Program	

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**
	term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between DHH and the CCN, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the Contract between DHH and the CCN in its entirety in the subcontractor's agreement or by use of other language developed by the CCN and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.		Regulatory Requirements Appendix – Provider.	
6.13.1.34	Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the CCN's members and the CCN under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the CCN with written verification of the existence of such coverage.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.35	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	regulations and guidelines applicable to the provision of services under the CCN Program.			
6.13.1.36	Provide that the subcontract incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective. In the event that changes in the subcontract as a result of revisions and applicable federal or state law materially affect the position of either party, the CCN and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.37	Specify that the CCN and subcontractor recognize that in the event of termination of the Contract between the CCN and DHH for any of the reasons described in Contract between the CCN and DHH, the CCN shall immediately make available, to DHH, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the CCN's and its subcontractor's activities undertaken pursuant to the subcontract. The provision of such records shall be at no expense to DHH.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.38	Provide that the CCN and	Full	Addressed in Louisiana Medicaid and CHIP Program	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the CCN member.		Regulatory Requirements Appendix – Provider.	
6.13.1.39	Include a conflict of interest clause as stated in the Contract between DHH and the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.40	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in this RFP and Quality Companion Guide. The QAPI and UM requirements shall be included as part of the subcontract between the CCN and the subcontractor.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.41	Provide that all subcontractors shall give CCN immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor‘s ability to perform the services included in its contract with the CCN.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.42	Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.43	Specify that the subcontractor shall not assign any of its duties and/or	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	responsibilities as required in the Contract between DHH and the CCN without the prior written consent of the CCN.			
6.13.1.44	Specify that the CCN shall not prohibit or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is his or her patient: a) for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; b) for any information the enrollee needs in order to decide among all relevant treatment options; c) for the risks, benefits, and consequences of treatment or non-treatment; and d) for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.45	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	benefits and services provided under the subcontract.			
6.13.1.46	Contain no provision which restricts a subcontractor from subcontracting with another CCN or other managed care entity.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.47	Provide that all records originated or prepared in connection with the subcontractor's performance of its obligations under the subcontract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the subcontractor in accordance with the terms and conditions of the Contract between DHH and the CCN. The subcontract must further provide that the subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under the Contract between DHH and the CCN and as further required by DHH, for a period of six (6) years from the expiration date of the Contract between DHH and the CCN, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the six (6) year	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

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**
	period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the six (6) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche or other electronic means, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within twenty-one (21) calendar days of the request.			
6.13.1.48	State that compensation to the CCN or individuals that conduct utilization management activities is not structured so as to provide incentives for the individual or CCN to deny, limit, or discontinue medically necessary services to any member.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.49	Provide that subcontractors, as applicable, register all births through LEERS (Louisiana Electronic Event Registration System) administered by DHH/Vital Records Registry.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.13.1.50	Provide that PCP's subcontract specify the maximum number of linkages the CCN may link to the PCP. The subcontract shall also stipulate that by signing the subcontract the PCP confirms that the PCP's total number of Medicaid members for the CCN Program will not exceed 2,500 lives.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.14	**Provider-Member Communication Anti-Gag Clause**			
6.14.1	The CCN shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether benefits for such care or treatment are provided under the Contract, for the following: the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; any information the member needs in order to decide among relevant treatment options; the risks, benefits and consequences of treatment or non-treatment; and the member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	Full	Addressed in Louisiana Medicaid and CHIP Program Regulatory Requirements Appendix – Provider.	
6.14.2	Any CCN that violates the anti-gag provisions shall be subject to intermediate sanctions.	N/A	DHH action item	
6.14.3	The CCN shall comply with the provisions concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	Full	Addressed in Louisiana Medicaid and CHP Program Regulatory Requirements Appendix – Provider	

Provider Network				
State Contract Requirements [Federal Regulation: 438.102, 438.206, 438.207, 438.214, 438.224, 438.230]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
6.14.4	The CCN shall submit all major subcontracts, excluding provider subcontracts, for the provision of any services under this RFP to DHH for prior review and approval. DHH shall have the right to review and approve or disapprove any and all provider subcontracts entered into for the provision of any services under this RFP.	Full	Addressed in UHS (5708-A) UHCLA Mgmt Agrmt Approval 121010; and UHS (5708-B) UHCLA Mgmt Agrmt Approval 080212.	
6.14.5	The CCN shall monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards; and	Full	Addressed in UHS (5708-B) UHCLA Mgmt Agrmt AM01 020112.	
6.14.6	The CCN shall identify deficiencies or areas for improvement, and take corrective action.	Full	Addressed in UHS (5708-B) UHCLA Mgmt Agrmt AM01 020112.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.0.0	The CCN shall possess the expertise and resources to ensure the delivery of enhanced primary care case management and PCP care management services to CCN members in accordance with the provisions of this RFP, and Medicaid rules and regulations. These services shall include, but not be limited to, referral to and coordination of authorized services to any of the Medicaid providers where a referral has been made; chronic care management; member services, and quality management.	Full	Primary care case management, PCP care management, referral, coordination and chronic care management are addressed in the following sections of this tool with citations by this reviewer. Member services and quality management are addressed by other reviewers. Primary care case management, PCP care management, referral, coordination are addressed throughout the CCN-S Physician Handbook (p. 57-68). Case management, chronic care management and referral and coordination are addressed throughout PCCM13 Case Management Program Description 3 27 2013_MEDICAL_OPTUM and NCM002 High Risk Case Management Process 3_27_13. Member services and quality management were audited by other reviewers.	
7.1	**Care Management**			
7.1.0.1	Care management is defined as the overall system of medical management encompassing, but not limited to, Referrals, Utilization Management, Case Management, Care Coordination, Continuity of Care, Care Transition Chronic Care Management, and Independent Review. The CCN shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for	Full	Care management is defined (Referrals, UM, CM, Care Coordination, Continuity, Transitions, Chronic Care Management and Independent Review) throughout the annually updated Utilization Management Program Description. The roles and responsibilities of the Primary Care Physician are defined in the CCN-S Physician Handbook (p. 57-68).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	coordinating Medicaid authorized services provided to the member.			
7.1.0.2	The CCN shall be responsible for ensuring: member's health care needs and services are planned and coordinated through the CCN PCP; accessibility of services and promoting prevention through qualified medical home practices which requires the provision for reasonable and adequate hours of operation including 24/7 availability of information, referral, and treatment for emergency medical conditions; and care coordination and referral activities, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services without compromise to quality of care. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical and/or behavioral health services.	Full	The Patient Centered Medical Home, access, assessment, emergency treatment, monitoring, follow-up and scheduling assistance (procedures for same-day, urgent and non-urgent care, triage and member education, outreach for missed appointments) are addressed in the CCN-S Physician Handbook (p. 26-27 and 56-59). PCP coordination of behavioral health services is addressed throughout the Handbook (beginning with p.7).	
7.1.1	**Referrals**			
7.1.1.0.1	The CCN shall have a referral system for CCN members requiring specialty health care services to ensure that services can be furnished to enrollees promptly and without compromise to care.	Full	Referral guidelines (including out-of-network referrals for continuity of care) are addressed in the CCN-S Physician Handbook (p. 26). Specialty care must be available within one month of referral or as clinically indicated (Handbook, p. 59).	
7.1.1.0.2	The CCN shall provide the coordination necessary for referral	Full	Referral guidelines are addressed in CCN-S Physician Handbook (p.26). Specialists, hospitals, labs and x-rays	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	as appropriate, of CCN members to, including but not limited to, specialty physicians, hospitals, lab and x-ray, ancillary service providers, and home health; that are available through fee-for service Medicaid providers.		(by condition) and home health (and how to access) are addressed in the Benefits Grid (p.11). Accessing services through Fee-for-Service Medicaid is discussed on p.57.	
7.1.1.0.3	The CCN shall assist the member in determining the need for services outside the CCN network and refer the member to the appropriate service provider.	Full	Member assistance/out of network referrals are addressed in the CCN-S Physician Handbook (p.17, 25), the Bayou Health Member Handbook (p.10) and in the policy UCSMM 06.21 Out of Network Requests and Continuing Care.	
7.1.1.0.4	The referral system must include processes to ensure monitoring and documentation of specialty health care services (e.g., medications prescribed, treatment received, recommendations for care), and follow up are included in the PCPs member medical record.	Full	Required monitoring and follow-up are addressed in Referral Guidelines (p.25) and Responsibilities of the PCP (p.57) of the CCN-S Physician Handbook Required monitoring and documentation of specialty services is ensured by medical record review (Handbook, p. 63).	
7.1.1.1	The CCN shall submit referral system policies and procedures to DHH for review and approval within thirty (30) days from the date the Contract is signed by the CCN, annually thereafter, and prior to any revisions. Referral policies and procedures shall describe referral systems and guidelines and, at a minimum, include the following:	Full	The CCN-S Physician Handbook, which addresses referral policies, states on the cover "Pending additional updates and state of Louisiana Department of Health and Hospitals approval." In general, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further suggested a tool tracking all submissions to the state be developed. Note: the health plan response to this element also noted "There is no referral to specialist requirement in the state of LA."	
7.1.1.1.1	When a referral from the member's PCP is and is not required;	Full	The far-right column of the Benefit Grid in the CCN-S Physician Handbook (p.11) displays when no referral	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			number or prior authorization is needed. Note: The prior authorization list was accessed by searching the provider site of UHCCommunityPlan.com as directed in the Handbook (p.23). Upon interview, the Health Services Director also offered to provide a list in-progress.	
7.1.1.1.2	Process for member referral to an Medicaid provider who has the appropriate training or expertise to meet the particular health needs of the member;	Full	The CCN-S Physician Handbook, Section Responsibilities of the PCP (p.25) contains the requirement as stated.	
7.1.1.1.3	Process for providing a standing referral when a member with a condition requires on-going care from a specialist;	Full	The CCN-S Physician Handbook addresses on-going referrals to specialists (p.30).	
7.1.1.1.4	Process for referral to specialty care for a member with a life-threatening condition or disease who requires specialized medical care over a prolonged period of time;	Full	The CCN-S Physician Handbook addresses on-going referrals to specialists when the patient's condition warrants (p.30).	
7.1.1.1.5	Process for member referral for case management;	Full	The CCN-S Physician Handbook states a member may be referred to case management or chronic care management by calling the provider services department (p.30).	
7.1.1.1.6	Process for member referral for chronic care management;	Full	The CCN-S Physician Handbook states a member may be referred to case management or chronic care management by calling the provider services department (p.30).	
7.1.1.1.7	Prohibit providers from making referrals for designated health services to health care entities with which the provider or a member of	Full	The CCN-S Physician Handbook, Section Responsibilities of the PCP (p.25) contains the requirement as stated.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the provider's family has a financial relationship.			
7.1.1.1.8	Processes to ensure monitoring and documentation of specialty health care services and follow up are included in the PCP's member medical record.	Full	Required monitoring and documentation of specialty services is ensured by medical record review (CCN-S Physician Handbook, p. 63).	
7.1.1.1.8.1	There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the specialty health care provider and the primary care provider; and	Full	The CCN-S Physician Handbook, section Medical Record Review (p.63) stipulates this requirement.	
7.1.1.1.9	Process for referral of members for services that are outside of the core benefits and services which will continue to be provided by enrolled Medicaid providers.	Full	Addressed by the CCN-S Physician Handbook, section Referral Guidelines (p.25).	
7.1.1.1.10	DHH strongly encourages the CCN to develop electronic, web-based referral processes and systems. In the event a referral is made via the telephone, the CCN shall ensure that referral data, including the final decision, is maintained in a data file that can be accessed electronically by the CCN, the provider and DHH.	Full	UHC Community Plan promotes web-based functionality among its provider population via a provider portal, and publishes the required technical specifications for telephonic referrals (CCN-S Physician Handbook, p.69). Data interchange and the Accountable Care Registry are discussed in SD-1A The PCMH Implementation Plan.	
7.1.5	**Care Coordination, Continuity of Care, and Care Transition**			
7.1.5.0.1	The CCN shall develop and maintain effective coordination, continuity of care, and care transition activities	Full	Coordination, continuity and transition are addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised). An	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	which ensure a continuum of care approach to providing health care services to CCN members. The CCN shall establish a process to coordinate the delivery of primary care services with other services that are reimbursed fee-for-service by DHH.		extensive list of services as defined by the Louisiana Medicaid State Plan is provided (p.2). Coordination of care is also addressed throughout the CCN-S Physician Handbook.	
7.1.5.0.2	The CCN shall ensure member-appropriate PCP choice within the CCN and interaction with providers outside the CCN. Continuity of care activities shall ensure that the appropriate personnel, including the PCP, are kept informed of the member's treatment needs, changes, progress or problems. Continuity of care activities shall provide processes by which CCN members and network and/or non-network provider interactions are effective and shall identify and address those that are not effective. The CCN shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that a CCN member may encounter.	Full	PCP choice and communication regarding member status are addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised). The policy states the plan will continuously work with providers to overcome any barriers to care, external or internal. Continuity activities could include processes to identify and address ineffective interactions.	
7.1.5.1	Coordination of Medicaid State Plan Services - The CCN shall be required to provide service authorization, refer, coordinate, and/or provide assistance in scheduling medically necessary services consistent with the standards as defined in Louisiana State Medicaid Plan	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	regarding service limits and service authorization requirements with the exception of physician visits.			
7.1.5.1.0.1	The CCN shall have policies and processes to authorize physician visits in excess of the 12 visit limit consistent with adult prior authorization requirements currently in Medicaid FFS. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services authorizations are not subject to this 12 service limit.	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.3).	
7.1.5.1.0.2	Policy transmittals, State Plan amendments, regulations, provider bulletins, provider manuals, and fee schedules, issued by DHH are the final authority regarding services.	Substantial	The CCN-S Physician Handbook states on the cover "Pending additional updates and state of Louisiana Department of Health and Hospitals approval." PCCM13 Case Management Program Description 3 27 2013_MEDICAL_OPTUM states (p.1) "All the terms and conditions of a member's plan and special programs are subject to, and governed by, applicable contract, State and federal laws, regulations and policies." However, language designating DHH authority by the listed DHH publications was not found in all submitted documents for this element. In general, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further suggested a tool tracking all submissions to the state be developed.	MCO response: UHC will add language to all publications, policies and procedures regarding DHH approval annually and prior to any revisions. A tracking tool is already in use for submissions to DHH. IPRO response: Determination is unchanged. Policies will be reviewed as part of next year's audit.
7.1.5.1.0.3	The CCN shall be responsible to coordinate the following Louisiana Medicaid State Plan services: Inpatient Hospital Services,	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Inpatient Hospital Services, Outpatient Services, Ancillary Medical Services, EPSDT/Well Child Visits, Emergency Medical Services, Communicable Disease Services, Emergency Medical Transportation, Home Health Services, Family Planning Services, Basic Behavioral Health Services, School-Based Health Clinic Services, Physician Services, Maternity Services, Organ Transplant and Related Services, Chiropractic Services, Rehabilitation Therapy Services (physical, occupational, and speech therapies), Federally Qualified Health Clinics, (FQHC)/Rural Health Clinics (RHC) Services.			
7.1.5.1.1	The CCN will not be responsible to pre-process or provide service authorization, but shall provide any required referrals and coordination, for the following services: Services provided through DHH's Early Step Services (IDEA Part C Program Services); Dental Services; Personal Care Services (EPSDT and LTPCS); Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Services; Home & Community-Based Waiver Services; Hospice Services; Non-Emergency Transportation; School-based Individualized Education Plan (IEP) Services provided by a school district and billed through the intermediate school district;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Nursing Facility Services; Pharmacy (Prescription Drugs); Specialized Behavioral Health Services; Targeted Case Management; Durable Medical Equipment and certain supplies; and Prosthetics and orthotics; and			
7.1.5.1.2	The CCN shall implement DHH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:	N/A		
7.1.5.1.2.1	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.1).	
7.1.5.1.2.2	Coordinate care between PCPs and specialists;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	
7.1.5.1.2.3	Coordinate care for out-of-network services, including specialty care services;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	
7.1.5.1.2.4	Coordinate CCN provided services with services the member may receive from other health care providers;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	
7.1.5.1.2.5	Share with other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.2).	
7.1.5.1.2.6	Ensure that in the process of	Full	Addressed in PCCM9 Coordination, Continuity and	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164 subparts A and E, to the extent applicable and other applicable state or federal laws;		Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.3).	
7.1.5.1.2.7	Maintain and operate a formalized hospital and/or institutional discharge planning program;	Full	Addressed in PCM13_06 14 IP-B Acute ICM Workflow_MEDICAL_OPTUM (Revised). The Acute Inpatient Management Workflow policy addresses the following settings: Acute Inpatient, Skilled Nursing Facility, Acute or Sub-Acute Rehab, Long Term Acute Care, Psychiatric and Maternity.	
7.1.5.1.2.8	Coordinate with hospital and/or institutional discharge planning that includes post-discharge care as appropriate;	Full	Addressed in PCM13_06 14 IP-B Acute ICM Workflow_MEDICAL_OPTUM (Revised) (p.3).	
7.1.5.1.2.9	Identify members using emergency department services inappropriately and assist in scheduling follow-up care with PCP and/or appropriate specialists;	Full	Incidence, case-finding and measuring CM effectiveness of ED utilization are addressed in PCCM13 Case Management Program Description 2 27 2013_MEDICAL_OPTUM and utilization assessment in NCM002 High Risk Case Management Process 3_27_13. Upon interview, health plan staff provided several presentations, including LA-specific interventions and outcomes, regarding member identification and engagement (as well as an on-going PIP addressing ER use in children with asthma). A care plan with an ER-use specific goal as shared with the PCP was also submitted. Member-level interventions (e.g., assisting with follow-up care) are in process, and were noted during file review, and could be included in Program Descriptions.	
7.1.5.1.2.10	Document authorized referrals in its	Full	NCM002 High Risk Case Management Process 3_27_13	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	utilization management system; and		states all referrals to providers and community resources to support the POC are entered in the care management system (p.3). When asked about documentation in the UM system, the Health Services Director supplied UCSMM.06.14 Initial Clinical Review, the Benefits list (services with no referrals are needed) and Prior Authorization List (services with pre-authorization needed) to demonstrate documentation and review in the UM system.	
7.1.5.1.2.11	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the CCN. The CCN shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less.	Full	Addressed in PCM9 Coordination, Continuity and Transition of care v2_11 15 11_MEDICAL_OPTUM (Revised) (p.1) and evidenced in the letter Notice to Member of Provider Termination.	
7.1.5.1.4	Continuity for Behavioral Health Care	N/A		
7.1.5.1.4.1	The PCP shall provide basic behavioral health services and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	Full	Addressed by the CCN-S Physician Handbook (p.7, 9, 13, 14, 16) and PCCM10_LA CCN-S BH Coordinator Statement of Work (p.2).	
7.1.5.1.4.2	In order to ensure continuity and coordination of care for members	Full	Addressed by the CCN-S Physician Handbook (p.7, 9, 13, 14, 16) and PCCM10_LA CCN-S BH Coordinator	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	who needs specialized behavioral health services or who may require inpatient/outpatient behavioral health services, the CCN shall be responsible for referring to the fee-for-service system or other managed care arrangement responsible for specialized behavioral health services (as applicable) for services.		Statement of Work.	
7.1.5.1.4.3	In any instance when the member presents to the network provider, including calling the CCN's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the CCN shall instruct the member to seek help from the nearest emergency medical provider. The CCN shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	Full	Direction to a member in a behavioral health crisis is addressed in LA_CCN-S_B-I_Final 6_24_11_REDACTED (p.128). Follow-up within 48 hours is addressed in PCCM10_LA CCN-S BH Coordinator Statement of Work (p.2).	
7.1.5.1.4.4	The CCN shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health provider.	Full	Addressed in PCCM10_LA CCN-S BH Coordinator Statement of Work (p.2).	
7.1.5.1.4.5	The network shall provide procedures and criteria for making referrals and coordinating care with behavioral health providers and	Full	Addressed in PCCM10_LA CCN-S BH Coordinator Statement of Work (p.2).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	agencies that will promote continuity, as well as, cost effectiveness of care.			
7.1.5.1.4.6	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple provides, facilities and agencies and require complex coordination of benefits and services.	Full	Addressed in PCCM10_LA CCN-S BH Coordinator Statement of Work (p.2).	
7.1.5.1.4.7	The CCN shall provide or arrange for training of providers and care managers on identification and screening of behavioral health conditions and referral procedures.	Full	Addressed in PCCM10_LA CCN-S BH Coordinator Statement of Work (p.3).	
7.1.5.2	Care Transition	N/A		
7.1.5.2.1	The CCN shall provide active assistance to members when transitioning to another provider (CCN or Medicaid FFS programs).	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.3) and UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.6).	
7.1.5.2.2	The receiving CCN shall be responsible for the provision of medically necessary services covered under the Contract that are required for the member during the transition period. The transition period shall not exceed thirty (30) calendar days from the effective date of the member's enrollment in the receiving CCN. During this	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.1, 4) and UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.6).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	transition period, the receiving CCN shall be responsible for notification to the new PCP of member's selection, initiation of the request of transfer for the member's medical files, arrangement of medically necessary services (if applicable) and all other requirements for new members.			
7.1.5.2.3	If a member is to be transferred between CCNs but is hospitalized at the time, the transfer shall be effective for the date of enrollment into the receiving CCN. However, the relinquishing CCN shall notify the receiving CCN of the member's hospitalization status within five (5) business days.	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.4) and UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.6).	
7.1.5.2.4	Upon notification of the member's transfer, the receiving CCN shall request copies of the member's medical record, unless the member has arranged for the transfer. The previous provider shall transfer a copy of the member's complete medical record and allow the receiving CCN access (immediately upon request) to all medical information necessary for the care of that member. Transfer of records shall not interfere or cause delay in the provision of services to the member. The cost of reproducing and forwarding medical records to the receiving CCN shall be the responsibility of the relinquishing	Full	Addressed in UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.7).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	CCN. A copy of the member's medical record and supporting documentation shall be forwarded by the relinquishing CCN's PCP within ten (10) business days of the receiving CCN's PCP's request.			
7.1.5.2.5	Appropriate medical records and case management files of the transitioning member shall also be transmitted. The cost, if any, of reproducing and forwarding medical records shall be the responsibility of the relinquishing Contractor.	Full	Addressed in UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.7).	
7.1.5.2.7	The CCN shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the DHH Medicaid Coordinated Care Section staff and staff from other CCNs to ensure a safe and orderly transition.	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.3) and UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.7).	
7.1.5.2.8	When relinquishing members, the CCN is responsible for timely notification to the receiving CCN regarding pertinent information related to any special needs of transitioning members. The CCN, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing Contractor so services are not interrupted, and for providing the new member with CCN and service information, emergency numbers and	Full	Addressed in PCCM9 Coordination, Continuity and Transition of Care_v2_11 15 11_MEDICAL_OPTUM_(Revised) (p.4) and UCSMM 06 21 Out of Network Requests and Continuing Care, Medicaid Policy Addendum (p.7).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	instructions on how to obtain services.			
7.1.6	**Case Management**			
7.1.6.0.1	The CCN shall develop and implement a case management program through a process which provides that appropriate and cost-effective medical services, medically-related services, other services, and behavioral health services are identified, planned, obtained and monitored for identified members who are high risk or have unique, chronic, or complex needs.	Full	Compliance is noted throughout the 2013 Case Management Program Description_3 27 2013, particularly by virtue of various section headings. The required language (identified, planned, obtained and monitored) could be included in Section II, Objectives (p.3).	
7.1.6.0.2	The process shall integrate the member's and case manager's review of the member's strengths and needs resulting in a mutually agreed upon appropriate and cost-effective service plan that meets the medical, functional, and behavioral health needs of the member.	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Plan of Care (p.11).	
7.1.6.0.3	The case manager should assist/facilitate the discharge planning process when assistance is needed to ensure patients receive care deemed medically necessary by the treating physician.	Full	Addressed in PCM13_06 14 IP-B Acute ICM Workflow_MEDICAL_OPTUM (Revised) and in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Transition Case Management (p.7).	
7.1.6.0.4	The CCN shall submit case management program policies and procedures to DHH for approval within thirty (30) days of the date	Full	The health plan response was titled "Standard 7.1.6.0.4, 7.1.6.1.2, 7.1.7.1.1 Narrative," and stated "Policies were submitted to DHH per Contract requirements Jan 2013. Unable to locate Attestation	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the Contract is signed by the CCN and annually thereafter.		Statements as they may not have been requested." PCCM13 Case Management Program Description 2 27 2013_MEDICAL_OPTUM states (p.1) "All the terms and conditions of a member's plan and special programs are subject to, and governed by, applicable contract, State and federal laws, regulations and policies." In general, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further suggested a tool tracking all submissions to the state be developed.	
7.1.6.1	Case Management Functions	N/A		
7.1.6.1.1	Case management functions shall include, but are not limited to:	N/A		
7.1.6.1.1.1	Early identification of members who have or may have special needs;	Full	Processes are detailed in NCM001 Identification of High Risk Members for Case Management. 3 27 2013.	
7.1.6.1.1.2	Assessment of a member's risk factors;	Full	NCM001 Identification of High Risk Members for Case Management. 3 27 2013 describes screening of all new members (Health Risk Assessment). The 2013 Case Management Program Description_3 27 2013 (Section VII. CM Program Components, Comprehensive Health Assessment) describes assessment of risk for members in any CM program (p.10). NCM002 High Risk Case Management Process 3 27 2013 describes assessment of risk for members in the HRCM program (Section V. Policy Provisions, A. Assessment). File review: 15/15 CM files contained one or more HRA, Comprehensive Assessment and supplemental	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			assessments as indicated.	
7.1.6.1.1.3	Education regarding Patient-Centered Medical Home and referral to a Medical Home when appropriate;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Enrollment and Program Information (p.10).	
7.1.6.1.1.4	Development of an individualized treatment care plan which must be: developed by the member's PCP, with enrollee participation, and in consultation with any specialists caring for the member; approved by the CCN in a timely manner if required by the CCN; and in compliance with applicable QA and UM standards;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Plan of Care (p.11) and NCM002 High Risk Case Management Process 3 27 2013. File review: 15/15 CM files contained a plan of care (POC), both as a stand-alone form and throughout the progress notes.	
7.1.6.1.1.5	Referrals and assistance to ensure timely access to providers;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section V, Organization Structure, Staffing, Training and Performance Evaluation, (p.6, Navigator) and Section VII. CM Program Components, Plan of Care (p.11). Addressed NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, B. Individual Care Plan Development, 7.	
7.1.6.1.1.6	Care coordination that actively links the member to providers, medical services, residential, social, community and other support services where needed;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Plan of Care (p.11). Addressed NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, B. Individual Care Plan Development, 7. File review: 15/15 CM files showed active linkage to medical and support services.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.6.1.1.7	Monitoring;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Monitoring and Evaluation (p.11). Addressed NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, C. Member Engagement, 2. File review: 14/15 files contained evidence of ongoing monitoring. 1 file was N/A as contact with member was lost after initial assessment.	
7.1.6.1.1.8	Continuity of care; and	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section V, Organization Structure, Staffing, Training and Performance Evaluation, (p.5, Case Manager) and Section VI. Description of CM Programs, Transition Case Management (p.7).	
7.1.6.1.1.9	Follow-up and documentation.	Full	Monitoring follow-up and documentation are addressed throughout the 2013 Case Management Program Description_3 27 2013. Addressed NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, B. Plan of Care, C. Member Engagement, F. Case Management Documentation.	
7.1.6.1.2	Case Management Policies and Procedures - The CCN shall submit Case Management Program policies and procedures to DHH for approval within thirty (30) days from date the Contract is signed by the CCN, annually thereafter, and subsequent to any revisions. Case Management policies and procedures shall, at a minimum, include the following elements:	Substantial	Per Standard 7.1.6.0.4, 7.1.6.1.2, 7.1.7.1.1 Narrative, "Policies were submitted to DHH per Contract requirements Jan 2013. Unable to locate Attestation Statements as they may not have been requested." As per 7.1.6.0.4 above, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further recommended that a tool tracking all submissions to the state be developed.	MCO response: Tracking Tool is being currently maintained by Compliance Officer per recommendation. UHC can add an Addendum for clinical policies to indicate that Policies require approval annually or prior to any revisions per Contract language. IPRO response: Determination is unchanged. Policies and tracking tool will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.6.1.2.1	A process to offer voluntary participation in the Case Management Program to eligible members;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Enrollment and Program Information (p.10). Addressed NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, A. Assessment, 3.	
7.1.6.1.2.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Risk Stratification (p.8). Addressed by NCM001 Identification of High Risk Members for Case Management 3 27 2013.	
7.1.6.1.2.3	The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment care plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These 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 throughout the 2013 Case Management Program Description_3 27 2013 and in NCM002 High Risk Case Management Process 3 27 2013. Note: Program description and policy terminology vary slightly from the contract language. Rather than short- and long-term treatment objectives, the CM PD utilizes goals and interventions, the HRCM Process utilizes goals and prioritization. However, short- and long-term goals, stated as such, were noted in progress notes upon file review, and goals of varying dates were entered in care plans. File review: 15/15 CM files contained assessments and plans of care with short- and long-term objectives. 14/15 POC showed monitoring and revisions. 1 was N/A for monitoring and revisions, as contact with member was lost after initial assessment. Note: Assessing the cultural and linguistic needs of	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			members is described in both the CM Program Description (p.11) and HRCM Process documents (Section V. A. Assessment, 5).	
7.1.6.1.2.4	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Plan of Care (p.11). Addressed NCM002 High Risk Case Management Process 3 27 2013 (Section V. Policy Provisions, B. Individual Care Plan Development, 1). File review: 15/15 CM files showed involvement of member or family member.	
7.1.6.1.2.5	Procedures and criteria for making referrals to specialists and subspecialists and follow-up of those referrals;	Full	CM promotion and follow-up of medical/behavioral specialist referrals are discussed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Plan of Care (p.11) (as are referral to community services in Section V.). Condition-specific interventions are displayed in Appendix B. Referrals (to providers, community resources), coordination and documentation are addressed NCM002 High Risk Case Management Process 3 27 2013. Referrals and follow-up were noted throughout the file reviews.	
7.1.6.1.2.6	Procedures and criteria for maintaining treatment care plans and referral services when the member changes PCPs; and	Full	The procedure is given in NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, C. Member Engagement, 3.	
7.1.6.1.2.7	Coordinate Case Management activities for members also receiving services through the CCN's	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VI. CM Program Description, Population Disease Management (p.7).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Chronic Care Management Program.		Condition-specific interventions are displayed in Appendix B. File review: 4/15 CM files showed evidence of coordination with the Chronic Care Management Program. The remaining 11 files were N/A: 1 member UTC after initial assessment, 1 member deceased within < one month of CM enrollment, 6 members were being case managed for acute conditions and/or transitions, 3 members were infants still hospitalized or newly-discharged.	
7.1.6.1.3	Identifying Individuals with Special Health Care Needs	N/A		
7.1.6.1.3.1	The CCN shall implement mechanisms to assess each Medicaid member identified or has self identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring to the CCN or PCP. The assessment mechanisms must use appropriate health care professionals. The CCN shall have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Full	Members with special needs are defined in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Risk Stratification (p.8) and included in all processes assessing quality and appropriateness of care. The use of appropriate health care professionals is addressed in Addressed in the 2013 Case Management Program Description_3 27 2013, Section V. Organizational Structure, Staffing, Training and Performance Evaluation (p.4).	
7.1.6.1.3.2	The CCN shall utilize historical claims data (if available) to identify members who meet CCN, DHH approved, guidelines for meeting SHCN criteria. The CCN must identify members with potential SHCN within ninety (90) days of	Substantial	Claims use and examples of SHCN are given in 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Risk Stratification (p.8) and in NCM001 Identification of High Risk Members for Case Management. 3 27 2013, Section V. B. Ongoing Identification and Evaluation of Members for HRCM.	MCO response: 1. UHC submitted the Case Management Plan. On page 8 it says we will complete a High Risk Assessment within 30 days. One of the results of that assessment is listed as a referral for Special Needs. 2. We submitted Policy NCM001. It says in Section V(B)(1)(c) we continually evaluate members who might

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	receiving the member's historical claims data (if available).		Claims use and examples of SHCN criteria including "other conditions or circumstances defined by contractual requirements" are given in NCM002 High Risk Case Management Process 3 27 2013. The 90-day requirement for identification of members with SHCN from claims was not found, and should be included in these 3 documents.	have special needs. 3. We submitted Policy NCM002. It says in Section V(A)(1) we will assess within 30 days from identification of the member as appropriate for high risk case management. In Section V(A)(5)(e) it says the assessment will include identification of Special Needs. 4. We submitted our policy SOP for Welcome Calls. It says all new members will be contacted within 30 days. One of the assessments embedded in this document, the Adult Assessment specifies a Risk Assessment. 5. We submitted an example of quarterly report 039, which counts the members assessed for special needs within 90 days, per the contract language. Since the references might be a bit obscure and difficult to find, UHC can update its policies to emphasize these time frames. UHC requests considering updating this rating to Full. IPRO response: Determination is unchanged. While the Case Management Plan specifies that a telephonic High Risk Assessment is completed for all members within 30 days of enrollment, the standard requires using claims data to identify members with special health care needs with the intent that targeted services be provided based on utilization. These two processes are not mutually exclusive and the plan should update its policies as stated in its response.
7.1.6.1.3.3	CCN PCPs shall identify members who meet SHCN criteria to the CCN. The PCP can identify members as having special needs at any time the member presents with those needs. The CCN must assess those members within ninety (90) days of	Full	The CCN-S Physician Handbook describes prospective identification of members for care management, noting "complex conditions" and physician referral for assessment (p.32). NCM002 High Risk Case Management Process 3 27 2013, Section V. Policy Provisions, A. Assessment, 1.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	identification. The assessment must be done by appropriate healthcare professionals.		states the CM will complete the Initial Comprehensive Assessment 30 days from identification, exceeding the 90-day requirement.	
7.1.6.1.3.4	Assessments that determine a course of treatment or regular care monitoring is appropriate shall result in a referral for Case Management. However, during the phase-in implementation of the Coordinated Care Program, DHH will extend this requirement to one hundred and eighty (180) days from the enrollment effective date.	Full	NCM001 Identification of High Risk Members for Case Management. 3 27 2013 describes screening of all new members (self-reported Health Risk Assessment), scoring and referral to the appropriate case management program (if indicated),	
7.1.6.1.3.5	The CCN must have a mechanism in place to allow enrollees with special health care needs to directly access a specialist(s) (for example, through a standing referral) as appropriate for the member's condition and identified needs.	Full	The far-right column of the Benefit Grid in the CCN-S Physician Handbook displays when no referral number or prior authorization is needed (p.11). The Handbook also addresses on-going referrals to specialists when the patient's condition warrants (p.30). Note: The health pan response states "No referral to Specialist requirement."	
7.1.6.1.4	Case Management Reporting Requirements - The CCN shall submit case management reports quarterly with an annual summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to the due date of those reports. The case management reports shall include, at a minimum: - Number of members identified	Substantial	All elements of required reports (Q1 and Q2, 2013) were reviewed, with the following notes: Note: Number of treatment plans completed was not included as a column heading. Also: Reasons for case closure included (A) unable to reach (B) switched plan (C) eligibility ended (D) non-compliance and Total. But upon file review, it was observed many cases were closed because all goals had been met.* The plan could include in reporting (1) the number of	MCO response: Report 039, Case Management Report on assessments is a template issued by DHH. It does not have columns for number of treatment plans or closed due to goals met. UHC is in full compliance with this report. UHC requests considering updating this rating to Full. IPRO response: Determination of "Substantial" remains unchanged. Though the plan is compliant in using the DHH template, the standard stipulates that DHH "reserves the right to request additional reports as deemed

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	with potential special healthcare needs utilizing historical claims data; - Number of members with special healthcare needs identified by the member's PCP; - Number of identified members with assessments; - Number of members with assessments resulting in a referral for Case Management; and - Number of treatment care plans completed.		treatment plans written, and (2) the number of treatment plans/cases closed when all goals were met. * Goal attainment is noted as a reason for case closure in NCM002 High Risk Case Management Process 3 27 2013, D. Case Closure, 1.A.	necessary" and requires plans to report the number of treatment plans completed. This element can be added as an accompaniment to the DHH report.
7.1.7	**Chronic Care Management Program (CCMP)**			
7.1.7.0	The CCN shall implement a Chronic Care Management Program (CCMP) for members with chronic conditions. The Chronic Care Management Program shall:	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VI. Description of CM Programs, Population Disease Management and High Risk Case Management (p.7).	
7.1.7.0.1	Emphasize prevention of exacerbation and complication of chronic diseases utilizing evidence based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope and II. Objectives. Note: The terms "exacerbation" and "complication" are not used; rather "improved health outcomes" and "optimized health and well-being." File review: 15/15 CCMP files contained goals around empowerment and self-management.	
7.1.7.0.2	Encourage the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope and II. Objectives.	
7.1.7.0.3	Address co-morbidities through a whole-person approach; and	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Scope and II. Objectives. File review: 14/15 CCMP files addressed co-morbidities. 1 file was N/A with no co-morbid conditions.	
7.1.7.0.4	Promote chronic care management strategies, such as: referral processes; after hours protocols, and targeted management to focus on those in greatest need.	Full	Referral processes are referenced throughout the 2013 Case Management Program Description_3 27 2013 (Incoming referrals p. 8, 9 and outgoing referrals p.5, 6, 11). After hour protocols are described in Section VII, Program Components, Accessibility. Targeted management is described in Section VII, Program Components, Member Identification and Risk Stratification. Risk stratification is detailed in UHC SQ044 A CCMP Predictive Modeling Specifications.	
7.1.7.1	The CCN shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Diabetes; and Congestive heart failure.	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VI. Description of CM Programs, Population Disease Management and High Risk Case Management (p.7).	
7.1.7.1.0	The CCN shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; sickle cell anemia, chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the CCN's discretion. The CCN shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VI. Description of CM Programs, Population Disease Management and High Risk Case Management (p.7). Population disease management includes COPD. Metrics (ER visits, admissions, readmissions) for all chronic conditions case were reviewed – including DKA and ESRD for diabetes (SQ042 CCMP Qtr2 2013 v3). The attestation as evidence of report submission was supplied.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	conditions in the CCMP, to DHH.			
7.1.7.1.1	CCMP Policies and Procedures - The CCN shall submit Chronic Care Management Program policies and procedures to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually and subsequent to any revisions. The CCN shall develop and implement policies and procedures that:	Full	Per Standard 7.1.6.0.4, 7.1.6.1.2, 7.1.7.1.1 Narrative, "Policies were submitted to DHH per Contract requirements Jan 2013. Unable to locate Attestation Statements as they may not have been requested." For chronic care management, as for case management, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further recommended that a tool tracking all submissions to the state be developed.	
7.1.7.1.1.1	Include the definition of the target population;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope.	
7.1.7.1.1.2	Include member identification strategies;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Risk Stratification (p.8). Also addressed by NCM001 Identification of High Risk Members for Case Management. 3 27 2013.	
7.1.7.1.1.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	Full	The Quality Management Committee minutes dated 1/5/12 and signed 1/10/12 state "The clinical practice guidelines were approved by the Medical Technology Assessment Committee (MTAC) in June 2011 and subsequently by National Quality Management Oversight Committee (NQMOC) in July 2011. They are posted on the provider portal."	
7.1.7.1.1.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section IV. Clinical Practice Guidelines (p.4). File review: 15/15 CCMP files contained a POC with	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	interventions;		interventions related to the member's chronic condition/conditions.	
7.1.7.1.1.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	Full	Stratification levels are included in the 2013 Case Management Program Description_3 27 2013, Appendix B: Condition Specific Interventions by Level for the 5 chronic conditions noted above. File review: 15/15 CCMP files contained the member's stratification level.	
7.1.7.1.1.6	Include methods for informing and educating members and providers;	Full	Members are provided educational materials, tools and support via written materials and telephonic outreach as described in the 2013 Case Management Program Description_3 27 2013, Section VI. Description of CM Programs (p.6) and providers are educated on Case Management processes as described in Section VII. Program components (p7). The CCN-S Physician Handbook also educates providers on care management activities (p.27-32) as does the Bayou Health Member Handbook (p.27-28).	
7.1.7.1.1.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope and II. Objectives. Note: The terms "exacerbation" and "complication" are not used; rather "improved health outcomes" and "optimized health and well-being."	
7.1.7.1.1.8	Conduct and report the evaluation of clinical, humanistic and economic outcomes;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope and II. Objectives.	
7.1.7.1.1.9	Address co-morbidities through a whole person approach;	Full	Addressed in the 2013 Case Management Program Description_3 27 2013, Section I. Introduction and Scope and II. Objectives.	
7.1.7.1.1.10	Coordinate CCMP activities for	Full	Addressed in the 2013 Case Management Program	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	members also identified in the Case Management Program; and		Description_3 27 2013, Section VI. Description of CM Programs. File review: 15/15 members in the CCMP were also case-managed.	
7.1.7.1.1.11	Include Program Evaluation requirements.	Full	Program Evaluation Requirements are included in the 2013 Case Management Program Description_3 27 2013, Section VIII. Program Evaluation. The 2012 C_S CM Program Evaluation Final_3 27 13 was submitted for review.	
7.1.7.1.2	Predictive Modeling - The CCN shall use predictive modeling methodology to identify and stratify members eligible for the CCMP.	Full	Described in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Stratification (p.8).	
7.1.7.1.2.1	The CCN shall submit specifications of its Predictive Modeling methodology, including its risk scoring, stratum, and healthcare guidelines to DHH for approval within thirty (30) days after the Contract is signed by the CCN, annually thereafter, and prior to any changes. These specifications shall include but are not limited to:	Full	Methodology, scoring, stratum and clinical guidelines are contained in UHC SQ044 A CCMP Predictive Modeling Specifications. In general, language regarding DHH approval annually and prior to any revisions could be added to all publications, policies and procedures. It is further recommended that a tool tracking all submissions to the state be developed.	
7.1.7.1.2.2	A brief history of the tool's development and historical and current uses;	Substantial (Determination changed to "Full")	History/historical use not seen in the submitted document UHC SQ044 A CCMP Predictive Modeling Specifications and could be added to the SOP (or CM PD or Program Evaluation Policy).	MCO response: United will add recommendations to Policy/Program Evaluation. A brief history of the tool's development and use is attached. UHC requests considering updating this rating to Full. IPRO response:

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				Determination is changed from "Substantial" to "Full." The document describing the history of the tool was reviewed and found to be complaint. It is recommended that a summary of the content of this document be incorporated into an existing Policy for completeness.
7.1.7.1.2.3	Medicaid data elements to be used for predictors and dependent measure(s);	Full	Medicaid data elements (sources) and some predictors (diagnoses) are described in the 2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Member Identification and Stratification (8). Dependent measures are described as 'level of future risk.' Levels of risk are detailed in the Program Description and UHC SQ044 A CCMP Predictive Modeling Specifications.	
7.1.7.1.2.4	Assessments of data reliability and model validity;	Non-Compliance (Determination changed to "Substantial")	The submitted document for this element (2013 Case Management Program Description_3 27 2013, Section VII. CM Program Components, Measurement of CM Effectiveness or Section VIII. Program Evaluation (both on p.12) does not address data reliability and model validity. Date reliability and model variability could be included in UHC SQ044 A CCMP Predictive Modeling Specifications.	MCO response: United will add addendum to SQ044A to add contractual requirement explanation. SQ044 A CCMP Predictive Modeling Specification Policy is an approved policy by DHH. This information is attached. UHC requests considering updating this rating to Full. IPRO response: Determination changed from "Non-compliance" to "Substantial". The documents supplied that describe the model's reliability are seemingly documents prepared by Impact Pro. The content of the documents should be summarized, highlighting the tool's predictive reliability findings, and incorporated into an existing plan policy.
7.1.7.1.2.5	A description of the rules and strategy to achieve projected clinical outcomes and how clinical outcomes shall be measured; and	Full	The 2012 C_S CM Program Evaluation measures health outcomes (e.g., engagement with provider, admission and re-admission rates) and rules/strategies based on risk stratification used to achieve improvement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Note: The health plan now utilizes a national CM model.	
7.1.7.1.2.6	A description of how the model has been optimized on these type interventions and the constraints on intervention to the Medicaid program and population.	Full	The use of the risk stratification model to re-structure the CM program and interventions is described in 2012 C_S CM Program Evaluation_FINAL_3 27 2013 with improvements (and limitations) noted. Note: The health plan utilizes a national CM model.	
7.1.7.1.3	Chronic Care Management Program Reporting Requirements - The CCN shall submit Chronic Care Management reports quarterly to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports. The CCMP reports shall contain at a minimum: - Total number of members; - Number of members in each stratification level for each chronic condition; and - Number of members who were disenrolled from the program and an explanation as to why they were disenrolled. The CCN shall submit an annual CCMP evaluation.	Full	All required elements and additional metrics (ER visits, admissions, readmissions) for all chronic conditions case were reviewed (SQ042 CCMP Qtr2 2013 v3). The attestation as evidence of report submission was supplied. CCMP evaluation was contained in the 2012 C_S CM Program Evaluation Final_3 27 13.	
7.2	**Behavioral Services**			
7.2.0	The CCN shall strongly support the integration of both physical and behavioral health services through	Full	Addressed in the CCN-S Physician Handbook 2013 (p.7, 9, 13).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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, or licensed professional counselors either in mental health clinics, mental health rehabilitation service providers (public or private), and other specialty behavioral health providers, to ensure the provision of services to members as specified in the Medicaid State Plan. Behavioral health services shall be divided into two levels:			
7.2.1	Basic behavioral health services shall include, but not be limited to, screening, prevention, early intervention, medication management, and referral services as defined in the Medicaid State Plan; and	Full	Addressed in the CCN-S Physician Handbook 2013 (p.7).	
7.2.1.1	Specialized behavioral health services shall include, but not be limited to, services specifically defined in state plan and provided by psychiatrists, psychologists, and/or mental health rehabilitation providers to those members with a primary diagnosis of a mental and/or behavioral disorder.	Full	Addressed in the CCN-S Physician Handbook 2013 (p.7).	
7.2.1.2	Basic Behavioral Health Services - The CCN shall be responsible for ensuring the provision of basic	Full	NCM006 Integration of Physical and BH Care 3 27 2013 states all new members are screened using a Health Risk Assessment which screens for behavioral health	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	behavioral health benefits and services to all members. The CCN PCPs shall utilize the screening tools and protocols approved by DHH.		related conditions.	
7.2.2	The CCN shall be responsible for providing basic behavioral health benefits and services to all members. The CCN shall utilize the screening tools and protocols approved by DHH. Basic behavioral health services/benefits shall include, but may not be limited to: - Screening, Prevention and Referral: - Screening, prevention, early intervention and referral services including screening services as defined in the EPSDT benefit (the EPSDT benefit guarantees coverage of —screening services which must, at a minimum, include —a comprehensive health and developmental history – including assessment of both physical and mental health: - Behavioral health services provided in the member's PCP or medical office as described under the —Basic Services section above(e.g., DO, MD); - Outpatient non-psychiatric hospital services, based on medical necessity; and - Those behavioral health services for individuals whose need for such services is secondary to a primary medical condition in any given	Full	Screening, Prevention, Referral services/benefits are addressed in the CCN-S Physician Handbook 2013, Benefits (p.7). Screening, prevention, early intervention and referral for the EPSDT benefit is addressed in the CCN-S Physician Handbook 2013, Benefits (p.9). EPSDT screening service details are provided in the CCN-S Physician Handbook 2013, Medical Record Documentation Standards (p.62). Basic BH services are covered in the CCN-S Physician Handbook 2013, Benefits (p.7). Outpatient non-psychiatric hospital services are covered in the CCN-S Physician Handbook 2013, Benefits (p.12). The need for BH services secondary to a primary medical condition is addressed CCN-S Physician Handbook 2013, Benefits (p.13).	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	episode of care.			
7.3	**Emergency Services**			
7.3.0	The CCN shall insure that emergency and post-stabilization services are coordinated without the requirement of prior authorization of any kind; and shall advise all CCN members of the provisions governing the use of emergency services. The CCN shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.	Full	Emergency services (no authorization or referral required) are covered in the CCN-S Physician Handbook 2013, Benefits (p.12) *and* members are informed in the LA-UHC CommunityPlan-Member Handbook (p.31). The prohibition on limiting what constitutes an emergency is addressed in UCSMM04 11 Consumer Safety (p.4).	
7.4	**Family Planning Services**			
7.4.0	The CCN shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The CCN family planning services shall also include preconception care services for members to optimize member health entering pregnancy. The CCN shall agree to make available all family planning services to CCN	Full	From CCN-S Physician Handbook 2013, Referral Guidelines, a referral to an out-of-network provider (specialist) for family planning is not needed (p.25). Services are listed in the Handbook section Benefits (p.10). Per the Health Services Director, claims are submitted and paid per standard procedure for Medicaid-enrolled providers.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	members as specified in on the Louisiana Medicaid State Plan. CCN members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the CCN's provider network without any restrictions. The out-of-network Medicaid enrolled family planning services provider will submit the claim to the CCN and will be reimbursed no less than the Medicaid rate in effect on the date of services by DHH's FI. CCN members should be encouraged by the CCN to receive family planning services through the CCN's network of providers to ensure continuity and coordination of the member's total care.			
7.6	**Women's Health Services**			
7.6.0	The CCN shall ensure direct access by female members to an OB/GYN within the provider's network (if the OB/ GYN is the member's PCP) or a OB/ GYN Member provider for routine OB / GYN services regardless of whether the PCP (general practitioner, family practitioner or internist) provides such services. Routine gynecological care shall mean a minimum of two routine annual visits, provided that the second visit shall be permitted based upon medical need only, and follow-up treatment provided	Substantial	Access to an in-network women's health specialist for routine and preventive women's health care services is addressed in the CCN-S Physician Handbook 2013 (p.25). Detailed language regarding this preventative service benefit was not found (e.g., 2 annual visits, with the second visit based on medical necessity, and follow-up provided within 60 days as needed). Although the Benefits sections in the provider handbook (p.7) and member handbook (p.13) cover adolescent, family planning and maternity benefits, a section specific to women's health, defining routine gynecological care, could be added.	MCO response: UHC can add more detailed description of women's preventive healthcare services in its Physician Handbook and Member Handbook, specifying 2 annual visits, with the second visit based on medical necessity, and follow-up provided within 60 days as needed. IPRO response: Determination is unchanged. Updated handbooks will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	within sixty (60) days following either visit if related to a conditions diagnosed or treated during the visits, and any care related to a pregnancy.			
7.7	**Cultural Considerations**			
7.7.0	The CCN shall promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CCN shall have written procedures for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, members with limited English Proficiency at no cost to the member. The provision for any needed interpretation services shall be the responsibility of the CCN.	Full	Addressed by the policy UHL_7/0_NCM013 Cultural Proficiency.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.1.2	**Utilization Management**			
7.1.2.0	The CCN shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review including service authorization and medical necessity review and are in accordance with the requirements set forth in this section and this RFP. The CCN shall submit UM policies and procedures to DHH within thirty (30) days from the date the Contract is signed by the CCN for written approval, and annually and subsequent to any revisions.	Full	Contains contract language and meets requirements. UCSMM 01.11 Document Oversight and Adherence	
7.1.2.1	The UM Program policies and procedures shall meet all URAC or NCQA standards and include medical management criteria and practice guidelines that: are adopted in consultation with subcontracting health care professionals; are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; consider the needs of the members; and are reviewed annually and updated periodically as appropriate.	Full	UCSMM 01.11 Document Oversight and Adherence contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.2.0	The policies and procedures shall include but not be limited to:	N/A		
7.1.2.2.0.1	The methodology utilized to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services;	Full	UCSMM 01.11 Document Oversight and Adherence contains contract language.	
7.1.2.2.0.2	The data sources and clinical review criteria used in decision making;	Full	Clause is included in UCSMM 01.11 Document Oversight and Adherence and UCSMM 06.10 Clinical Review Criteria addresses data sources. Findings from IPRO UM File Review 9/18/13: Letters of notification of denial consistently cite either Milliman or InterQual criteria. File documents information provider sends as evidence of member condition. File notes did document either Milliman or InterQual criteria taken into account for determination.	
7.1.2.2.0.3	The appropriateness of clinical review shall be fully documented;	Full	UCSMM 06.13 Initial Clinical Review UCSMM 01.11 Document oversight and Adherence UCSMM 06.18 Initial Adverse Determination Notice Contract language contained in above. IPRO UM file review findings 9/18/13: Clinical review is conducted by a credentialed physician using documentation in support of appropriateness of clinical review.	
7.1.2.2.0.4	The process for conducting informal reconsiderations for adverse determinations;	Substantial	Clause is included in UCSMM 06.15 Peer Clinical Review or UCSMM 01.11 Document Oversight and Adherence. IPRO Informal Reconsiderations File Review Findings 9/18-9/19/13: A process for conducting informal reconsiderations for adverse determinations was consistently followed; however documentation was unclear regarding date of provider request for informal reconsideration; therefore, reviewer was unable to determine timeliness based upon existing documentation. It was evident that	MCO response: UHC will review and refine the Policy and Procedure for documenting Informal Reconsiderations, including clarification of the date of provider request. IPRO response: Determination is unchanged. Updated policy will be reviewed as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			informal reconsideration was carried out using peer to peer telephone discussion and notification, using guidelines-based criteria used to guide resolution, with adequate opportunity for provider to present evidence. Recommendation: Improve documentation to clarify date of provider request for informal reconsideration. Of the 10 files reviewed, one file lacked documentation of resolution, successful follow-up contact, or notification regarding the reconsideration decision. A 2nd file also lacked resolution/notification; however, notes documented that P2P was scheduled and cancelled by the requesting provider.	
7.1.2.2.0.5	Mechanisms to ensure consistent application of review criteria and compatible decisions; and	Full	Inter-rater reliability discussed in UCSMM 06.10 Clinical Review Criteria and clause included in UCSMM 01.11 Document Oversight and Adherence.	
7.1.2.2.0.6	Data collection processes and analytical methods used in assessing utilization of healthcare services; and provisions for assuring confidentiality of clinical and proprietary information.	Full	Clause is included in UCSMM 01.11 Document Oversight and Adherence and UCSMM 03.10 Information Security.	
7.1.2.2.1	The CCN must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	N/A	UCSMM 6.10 Clinical Review Criteria identify the source.	
7.1.2.2.1.1	The vendor must be identified if the criteria was purchased;	Substantial	UCSMM 6.10 Clinical Review Criteria contain contract language. IPRO 9/19/13 UM File Review Findings: All adverse determination notification letters documented either Milliman Robertson or InterQual for	MCO response: Education and audits will continue to assure consistent documentation on all cases regarding informal reconsiderations. IPRO response:

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			medical necessity/level of care determinations, with the exception of the two informal reconsideration files without resolution/notification documented.	Determination is unchanged. File review will be conducted as part of next year's audit.
7.1.2.2.1.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	Full	UCSMM 6.10 Clinical Review Criteria contain contract requirements.	
7.1.2.2.1.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	Full	UCSMM 6.10 Clinical Review Criteria contain contract requirements.	
7.1.2.2.1.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals.	Full	UCSMM 6.10 Clinical Review Criteria contain contract language. IPRO UM File Review Findings 9/18/13: Review notes and notification letter indicate name of physician making medical necessity determinations.	
7.1.2.2.2	UM Program medical management criteria and practice guidelines shall be disseminated to all affected providers, members and potential members upon request.	Full	UCSMM 6.10 Clinical Review Criteria contain contract language.	
7.1.2.2.3	The CCN shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.	Full	Addressed in UCSMM 06.14 Initial Clinical Review. IPRO UM and Informal Reconsiderations File Review 9/18/13: Nurse Reviewers perform initial review using Milliman /Robertson and InterQual criteria and refer cases not meeting criteria to Medical Reviewer, with documentation in log files.	
7.1.2.2.4	The CCN shall use the medical	Full	UCSMM 06.15 Peer Clinical Review contains contract	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations.		language.	
7.1.2.2.5	The CCN must identify the qualifications of staff who will determine medical necessity.	Full	UCSMM 06.14 Initial Clinical Review meets contract language requirement. IPRO UM File Review 9/18/13: MD credentials indicated in notes and notification record.	
7.1.2.2.6	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	Full	UCSMM 06.15 Peer Clinical review meets contract language requirements.	
7.1.2.2.7	The CCN shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional competence or moral character; and The individual making these determinations is required to attest	Full	UCSMM 02.10 Staff Qualifications and Credentials, UCSMM 06.10 Peer Clinical Review contain contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.			
7.1.2.2.8	The CCN shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The CCN shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The CCN may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose.	Full	UCSMM 06.14 Initial Clinical Review contains contract language.	
7.1.2.2.8.1	The CCN shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the CCN can provide the service through an in-network or out-of-network provider for a lower level	Full	UCSMM 02.12 Performance Assessment and incentives contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of care.			
7.1.2.2.9	The CCN shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member.	Full	UCSMM 02.12 Performance Assessment and incentives contains contract language.	
7.1.2.2.10	The CCN shall disseminate Utilization Management practice guidelines to all affected providers, members, and potential members upon request. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	Full	Per 2012a UHC Clinical Practice Guidelines document, links to clinical guidelines are provided on provider website and the provider is notified.	
7.1.2.2.11	The CCN shall report fraud and abuse information identified through the UM program to DHH's Program Integrity.	Full	UCSMM 03.12 Regulatory compliance contains contract language.	
7.1.2.2.12	The CCN Utilization Review plan must provide that each enrollee's record includes information needed for the UR committee to perform UR required under this section. This information must include, at least, the following:	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.1	Identification of the enrollee;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.2	The name of the enrollee's physician;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.2.12.3	Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.4	The plan of care;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.5	Initial and subsequent continued stay review dates;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.6	Date of operating room reservation, if applicable;	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.2.12.7	Justification of emergency admission, if applicable.	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.3	Utilization Management Committee	Full	UCSMM 06.19 Information Based Clinical Review contains contract language.	
7.1.2.3.1	The UM program shall include a Utilization Management (UM) Committee that integrates with other functional units of the CCN as appropriate and supports the QAPI Program.	Full	UCSMM 01.10 Organizational structure contains contract language.	
7.1.2.3.2	The UM Committee shall provide utilization review and monitoring of UM activities of both the CCN and its providers and is directed by the CCN Medical Director. The UM Committee shall convene no less than quarterly and shall submit meeting minutes to DHH within five (5) business days of each meeting.	Full	UCSMM 01.10 Organizational structure contains contract language.	
7.1.2.3.3	UM Committee responsibilities include: monitoring providers' requests for rendering healthcare services to its members; monitoring	Full	UCSMM 01.10 Organizational structure contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the medical appropriateness and necessity of healthcare services provided to its members utilizing provider quality and utilization profiling; reviewing the effectiveness of the utilization review process and making changes to the process as needed; approving policies and procedures for UM that conform to industry standards, including methods, timelines and individuals responsible for completing each task; monitoring consistent application of medical necessity criteria; application of clinical practice guidelines; monitoring over- and underutilization; review of outliers, and Medical Record Reviews - reviews of member medical records shall be conducted to ensure that PCPs provide high quality health care that is documented according to established standards.			
7.1.2.4	Medical Record Review Strategy - The CCN shall maintain a written strategy for conducting medical record reviews, reporting results and the corrective action process. The strategy shall be provided within thirty (30) days from the date the Contract is signed by the CCN and annually thereafter.	Full	UHC SQ069 Ambulatory Medical Record Review and NQM-025 Ambulatory medical Record Review contain contract language.	
7.1.2.4.1	The strategy shall include, at a minimum, the following: designated staff to perform this duty; the	Full	Addressed in UHC SQ069Ambulatory Medical Record Review and NQM-025 Ambulatory Medical Record Review.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	method of case selection; the anticipated number of reviews by practice site; the tool the CCN shall use to review each site; and how the CCN shall link the information compiled during the review to other CCN functions (e.g. QI, credentialing, peer review, etc.). The standards, which shall include all medical record documentation requirements addressed in the Contract, shall be distributed to all providers.			
7.1.2.4.2	The CCN shall conduct reviews at all PCP sites with fifty (50) or more linked members and practice sites which include both individual offices and large group facilities. The CCN shall review each site at least one (1) time during each two (2) year period.	Full	SQ069_Utilization_Management_Report_Template contains contract language.	
7.1.2.4.3	The CCN shall review a reasonable number of records at each site to determine compliance. Five (5) to ten (10) records per site is a generally accepted target, though additional reviews shall be completed for large group practices or when additional data is necessary in specific instances.	Full	UHC SQ069 NQM-025 MRR Rider contains contract language.	
7.1.2.4.4	The CCN shall report the results of all medical record reviews to DHH quarterly with an annual summary.	Full	UHC SQ069 NQM-025 MRR Rider contains contract language.	
7.1.2.5	Reporting Requirements - The CCN shall submit utilization management	Full	188 UHC 2013 Q2 Prior authorization and pre-cert report provided.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	reports as specified by DHH. DHH reserves the right to request additional reports as deemed by DHH. DHH will notify the CCN of additional required reports no less than 30 days prior to due date of those reports.			
7.1.2.6	Service Authorization - Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	N/A	Definition	
7.1.2.6.0.1	The CCN shall provide service authorization only for those medically necessary services that require authorization under the Medicaid FFS system, with the exception of physician services as specified in § 7.1.5.1.1.	Full	UCSMM 06.14 Initial Clinical Review contains contract language.	
7.1.2.6.0.2	The CCN may only provider service authorization for abortions in the following situations in accordance with federal and state regulations:	N/A		
7.1.2.6.0.2.1	If the pregnancy is the result of an act of rape or incest; or	Full	UCSMM 06.14 Initial Clinical review contains contract language.	
7.1.2.6.0.2.2	In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would, as certified by a physician place the woman in danger of death unless an abortion is performed.	Full	UCSMM 06.14 Initial Clinical review contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.6.0.3	No other abortions, regardless of funding, can be provided as a benefit under the CCN Program.	Full	UCSMM 06.14 Initial Clinical review contains contract language.	
7.1.2.6.0.4	The CCN UM Program policies and procedures shall include service authorization policies and procedures in accordance with state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:	N/A		
7.1.2.6.0.4.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner;	Full	Addressed in UCSMM 06.14 Initial Clinical review.	
7.1.2.6.0.4.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	Full	UCSMM 06.10 Clinical Review Criteria contains contract requirements.	
7.1.2.6.0.4.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	Full	UCSMM 06.10 Clinical Review Criteria contains contract language/requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.2.6.0.4.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	Full	Addressed in UHL_12_Grivance Process and Requirements.	
7.1.2.6.0.4.5	The CCN's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and non-participating providers; and	Full	UCSMM 01.11 Document Oversight and Adherence contains contract language.	
7.1.2.6.0.4.6	The CCN‘s service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the CCN regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	Full	UCSMM 01.11 Document Oversight and Adherence, and UCSMM 03.10 Information Security contain contract language and meet contract requirements.	
7.1.2.6.1	Timing of Service Authorization Decisions	N/A		
7.1.2.6.1.1	Standard Service Authorization - In regard to standard authorization decisions, the CCN shall provide notice as expeditiously as the enrollee‘s health condition requires. The CCN shall make eighty percent (80%) of initial standard service authorization within two (2) business days of obtaining	Full	UCSMM 06.16 Review Timeframes contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination.			
7.1.2.6.1.1.2	Standard service authorizations shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension is requested. An extension may be granted for an additional fourteen (14) calendar days if: the member, or the provider, requests extension; or the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's best interest. The CCN shall make concurrent review service authorizations within one (1) business day of obtaining the appropriate medical information that may be required.	Substantial	UCSMM 06.16 Review Timeframes contains contract language. IPRO UM File Review Findings 9/18/13: 6 of 20 files reviewed were between 1-2 days beyond timing requirements.	MCO response: UHC will review procedures with appropriate staff, providing education, and continue to audit performance to assure compliance. IPRO response: Determination is unchanged. File review will be conducted as part of next year's audit. Educational efforts will also be reviewed.
7.1.2.6.1.2	Expedited Authorization Decisions - For cases in which a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCN must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires but no later than seventy-two (72)	Full	UCSMM 06.16 Review Timeframes contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	hours after receipt of the request for service.			
7.1.2.6.1.2.1	The CCN may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the CCN justifies to DHH upon request a need for additional information and how the extension is in the member's best interest.	Full	UCSMM 06.16 Review Timeframes contains contract language.	
7.1.2.6.1.3	Post Authorization - Decisions for authorization involving health care services that have been delivered shall be made within thirty (30) calendar days of receipt of the necessary information.	Full	UCSMM 06.16 Review Timeframes contains contract language.	
7.1.2.6.2	Notice of Action - The CCN shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action.	Substantial	UCSMM 06.18 Initial Adverse Determination Notice contains contract language. IPRO UM File Review 9/18/13: One file was without a notification letter. Most letters were sent to providers, and these, as well as those to members were easy to understand.	MCO response: Education and audits will continue to assure consistent process followed per State requirements. IPRO response: Determination is unchanged. File review will be conducted as part of next year's audit.
7.1.2.6.2.1	Approval - For service authorization approval for a nonemergency admission, procedure or service, the CCN shall notify the provider as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business	Full	UCSMM 06.16 Review Timeframes contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	days of making the initial certification. For service authorization approval for extended stay or additional services, the CCN shall notify the provider rendering the service, whether a healthcare professional or facility or both, and the member receiving the service within one (1) business day of the service authorization approval.			
7.1.2.6.2.2	Adverse Determination - The CCN shall notify the member, in writing using language that is easily understood, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action. The notice of action to members shall be consistent with requirements for member written materials. The CCN shall notify the requesting provider of a decision to deny an authorization request or to authorize a service in an amount, duration, or scope that is less than requested.	Full	UCSMM 06.18 Initial Adverse Determination Notice contains contract language.	
7.1.2.6.3	Exceptions to Service Authorizations and/or Referrals Requirements	N/A		
7.1.2.6.3.1	The CCN shall not require: service authorization for emergency services or post-stabilization services whether provided by an in network or out-of-network provider; hospital service authorization for nonemergency	Full	Contract language regarding exception of emergency services or post-stabilization whether provider in/out network included; i.e., UCSMM 04.11 Consumer Safety. Member Handbook also details which services require prior authorization and which do not.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	inpatient admissions for normal newborn deliveries; service authorization or referral for EPSDT screening services; service authorization for family planning services; service authorization for general eye care and vision services; a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CCN for routine and preventive women's healthcare services and prenatal care; a PCP referral for access to specialized behavioral health services; service authorization for the continuation of medically necessary State Plan services of a new member transitioning into the CCN, regardless of whether such services are provided by an in network or out-of network provider, however, the CCN may require prior authorization of services beyond thirty (30) calendar days. The CCN is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider.			
7.1.2.6.3.2	The CCN may request to be notified by the provider, but shall not deny claims for payment based solely on lack of notification, for the following: Inpatient emergency admissions within forty-eight (48) hours of admission; obstetrical care (at first visit); and obstetrical	Full	UCSMM 03.12 Regulatory Compliance contains contract language.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.			
7.1.3	Medical History Information -The CCN is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by DHH, for purposes of making medical necessity determinations. The CCN shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.	Full	Incorporated into contract language, i.e., UCSMM 06.19 Information Based Clinical Review.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
7.1.4	**PCP Utilization and Quality Profiling**			
7.1.4.1	The CCN shall profile its PCPs and analyze utilization data to identify PCP Utilization and/or quality of care issues. The CCN shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	Full	NQM-005 Provider Profiling Over and Under Utilization indicates MedMeasures is the mechanism to detect under and over utilization of services. NQM-017 Standardization of Handling QOC Level I issues addresses quality of care issues related to this requirement. Plan provided quarterly analyses addressing utilization data: UHC SQ072 PCP Profile 2012 Q3.xls UHC SQ072 PCP Profile 2012 Q4.xls UHC SQ072 PCP Profile 2013 Q1.xls UHC SQ072 PCP Profile 2013 Q2.xls UHC SQ072 PCP Profile 2012 Q3 AT.pdf UHC SQ072 PCP Profile 2012 Q4 AT.pdf UHC SQ072 PCP Profile 2013 Q1 AT.pdf UHC SQ072 PCP Profile 2013 Q2 AT.pdf Regarding utilization issues, the plan has created a letter for providers requesting assistance in encouraging the member to participate in case management. Regarding QOC issues, a quarterly report provided indicated these were addressed.	
7.1.4.2	The CCN shall submit individual PCP profile reports to DHH quarterly. CCN PCP profiling activities shall include, but are not limited to, the following: - Specialist referrals – The CCN shall	Full	SOP PCP Profile Monitoring Policy describes the plan procedure to identify and evaluate individual PCP profile reports and identify and evaluate member's utilization as well as PCPs as stated in the contract requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	maintain a procedure to identify and evaluate member specialty provider referral utilization by its PCP panel; - Emergency department utilization – The CCN shall maintain a procedure to identify and evaluate member emergency department referral utilization by its PCP panel; - Hospital admits, lab services, medications, and radiology services – The CCN shall maintain a procedure to identify and evaluate member's utilization; and - Individual PCP clinical quality performance measures as indicated in Appendix H.		UHC SQ072 Quarterly reports were reviewed, and addressed all the required areas: UHC SQ072 PCP Profile 2012 Q3.xls UHC SQ072 PCP Profile 2012 Q4.xls UHC SQ072 PCP Profile 2013 Q1.xls UHC SQ072 PCP Profile 2013 Q2.xls UHC SQ072 PCP Profile 2012 Q3 AT.pdf UHC SQ072 PCP Profile 2012 Q4 AT.pdf UHC SQ072 PCP Profile 2013 Q1 AT.pdf UHC SQ072 PCP Profile 2013 Q2 AT.pdf	
7.1.4.3	PCP Utilization & Quality Profile Reporting Requirements- The CCN shall submit profile reports quarterly with an Annual Summary to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than sixty (60) days prior to due date of those reports.	Full	UHC SQ072 Quarterly reports were submitted and reviewed meeting contract requirements: UHC SQ072 PCP Profile 2012 Q3.xls UHC SQ072 PCP Profile 2012 Q4.xls UHC SQ072 PCP Profile 2013 Q1.xls UHC SQ072 PCP Profile 2013 Q2.xls UHC SQ072 PCP Profile 2012 Q3 AT.pdf UHC SQ072 PCP Profile 2012 Q4 AT.pdf UHC SQ072 PCP Profile 2013 Q1 AT.pdf UHC SQ072 PCP Profile 2013 Q2 AT.pdf Annual Report: The CCN indicates that per State template, the annual summary is included with the Q4 report. The Q4 report had the years totals included.	
7.1.8	**Quality Management**			
7.1.8.0.1	The CCN shall have an ongoing Quality Assessment and Performance Improvement (QAPI)	Full	Policy NQM-048 Quality Improvement Program Policy the requirements of the contract.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	Program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. Improvement strategies include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys.		2012 UHCLA QI Program Description fully addressed stated contract requirements. UHC SQ121 QAPI Program Description 2013 describes a program that meets these contract requirements. NQM-025-Ambulatory Medical Record Review Process addresses medical record audits performed by plan. NQM 021 Evaluation of Interventions in Quality Improvement Projects addresses PIPs and QIPs improvement strategies policy.	
7.1.8.0.2	The CCN shall have mechanisms to 1) detect underutilization and overutilization of services and 2) assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Full	NQM-005 Provider Profiling Over and Under Utilization indicates MedMeasures as a mechanism to detect under and over utilization of services. 2013 Case Management Program Description describes a program addressing needs of those with special health care needs. 2012 C S CM Program Evaluation addresses assessing quality and appropriateness of care for members with special health care needs, meeting contract requirements.	
7.1.8.0.3	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care should receive priority in selection of QAPI activities.	Full	UHC SQ 216A 2012 Quality Improvement Program Evaluation is an annual summary which indicates these contract requirements are being met. Individual policies addressing these requirements include: NQM-003 HEDIS Data Auditing addressing accurate and complete reporting according to NCQA and State specifications. NQM-004 QOC Concerns addresses processes for monitoring, evaluating and addressing quality of care	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			concerns. NQM-021 Evaluation of Interventions in QIPs addressing the processes, monitoring and evaluation of quality improvement projects. NQM-029 Clinical Practice Guidelines is a policy describing keeping current on clinical practice guidelines with review, acceptance and adoption addressing effective healthcare management. NQM-049 Quality Improvement Projects describes the process for selection, planning, implementation, evaluation and reporting of quality improvement projects focused on high risk and high volume areas of patient care. NQM-055 Quality of Service Policy describes the process of monitoring, recording and investigating quality of service complaints.	
7.1.8.0.4	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	Full	2012 UHCLA QI Program Description fully addresses stated contract requirements. UHC SQ121 QAPI Program Description 2013 describes a program that meets this contract requirement. QMC Signed Minutes submitted indicated 6 meetings were held throughout 2012 and 2013 (6 meetings). Meetings met this contract requirement: 120517_QMC_Signed_Minutes.pdf, p. 3 120815_QMC_Signed_Minutes.pdf, pp. 3-5 120820_QMC_Signed_Minutes.pdf, p. 2 121016_QMC_Signed_Minutes.pdf, p. 3 121211_QMC_Signed_Minutes.pdf, p. 5 130123_QMC_Signed_Minutes.pdf, p. 6 130618_QMC_Signed_Minutes.pdf, pp. 3-5	
7.1.8.0.5	The CCN shall submit a QAPI Quality Assessment Work plan within thirty (30) days from the date the Contract is signed and annually	Full	Policy NQM-048 Quality Improvement Program Policy addresses this contract requirement. LA 2012 QI Workplan met contract requirement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	thereafter, for DHH review and approval.		UHC SQ121 QAPI Workplan was reviewed. The CCN provided an updated Quality Assessment Work plan that is updated and active.	
7.1.8.0.6	The CCN's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the CCN's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the CCN.	Full	NQM-048 Quality Improvement Program Policy addresses this contract requirement. UHC SQ 216A 2012 Quality Improvement Program Evaluation is an annual summary addressing these requirements.	
7.1.8.0.7	The CCN shall have a process in place to evaluate the impact and effectiveness of its QAPI program. DHH must approve any material change to this plan prior to implementation of the revisions.	Full	NQM-048 Quality Improvement Program Policy 0113.pdf, p. 3, #9 addresses this requirement. UHC SQ 216A 2012 Quality Improvement Program Evaluation is an annual summary indicating that a process is in place that addresses these requirements.	
7.1.8.1	QAPI Committee	N/A		
7.1.8.1.1	The CCN shall form a QAPI Committee.	Full	UHC SQ121 QAPI Program Description describes the QAPI Committee. QMC Meeting Agendas were reviewed as well as QMC Signed Minutes meeting these requirements: 120105_QMC_Meeting_Agenda.pdf 120412_QMC_Meeting_Agenda.pdf 120517_QMC_Meeting_Agenda.pdf 120815_QMC_Meeting_Agenda.pdf Note: for the 08/20/2012 meeting, there was no agenda because this was a special impromptu called meeting. 121016_QMC_Meeting_Agenda.pdf 121211_QMC_Meeting_Agenda.pdf	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			130123_QMC_Meeting_Agenda.pdf 130219_QMC_Meeting_Agenda.pdf 130327_QMC_Meeting_Agenda.pdf 130618_QMC_Meeting_Agenda.pdf 120105_QMC_Signed_Minutes.pdf 120412_QMC_Signed_Minutes.pdf 120517_QMC_Signed_Minutes.pdf 120815_QMC_Signed_Minutes.pdf 120820_QMC_Signed_Minutes.pdf 121016_QMC_Signed_Minutes.pdf 121211_QMC_Signed_Minutes.pdf 130123_QMC_Signed_Minutes.pdf 130219_QMC_Signed_Minutes.pdf 130327_QMC_Signed_Minutes.pdf 130618_QMC_Signed_Minutes.pdf	
7.1.8.1.2	The CCN Medical Director must serve as either the chairman or co-chairman.	Full	UHC SQ121 QAPI Program Description indicates the CCN Medical Director is the co-chairman. QMC signed minutes (see 7.1.8.1.1) indicates the plan Medical Director is the co-chairman.	
7.1.8.1.3	Appropriate CCN staff representing the various departments of the organization will have membership on the committee.	Full	UHC SQ121 QAPI Program Description indicates this requirement is met as there is plan staff from various departments as members of the committee. QMC signed minutes (see 7.1.8.1.1) indicates various departments are represented.	
7.1.8.1.4	The CCN is encouraged to include a member advocate representative on the QAPI Committee.	Full	UHC SQ121 QAPI Program Description describes a Service Quality Improvement Subcommittee that monitors the quality of service delivered to the plan's membership. A CCN response was received with the documentation of files and states the plan's Director of Marketing and Community Outreach serves on the committee as their member advocate. They do not have an external member advocate on the Quality Management	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Committee, although they do solicit feedback from the Member Advisory Council meetings.	
7.1.8.1.5	The QAPI Committee shall meet on a quarterly basis. Its responsibilities shall include: direct and review quality improvement (QI) activities; assure that QAPI activities take place throughout the CCN; review and suggest new and/or improved QI activities; direct task forces/committees to review areas of concern in the provision of healthcare services to members; designate evaluation and study design procedures; conduct individual PCP and practice quality performance measure profiling; report findings to appropriate executive authority, staff, and departments within the CCN; direct and analyze periodic reviews of members' service utilization patterns; and maintain minutes of all committee and sub-committee meetings; submit meeting minutes to DHH within 5 working days of the meetings; report to DHH an evaluation of the impact and effectiveness of its QAPI program annually. This shall include, but is not limited to, all care management services. Ensure that a QAPI committee designee attends DHH's quality meetings.	Substantial	UHC SQ121 QAPI Program Description indicates they meet on at least a quarterly basis. The responsibilities as describes in the contract requirements are included. UHC SQ216A QAPI Impact and Effectiveness of QAPI Program Evaluation is the annual report and included and an attestation indicating it was sent to DHH in February, 2013 describing the program as required in the contract requirements. LA 2012 QI Workplan was reviewed and addresses the timeline of the contract requirements. The minutes submitted did not indicate that they were delivered to DHH within 5 working days: 4/18/12 meeting approved and submitted minutes on 5/21/12. The 5/17/12 meeting had minutes approved and submitted on 8/20/12. The 8/15/12 meeting had minutes approved and submitted on 10/22/12. 1/23/13 meeting submitted 2/19/13. 2/19/13 submitted 5/3/13 and 3/27/13 submitted 6/4/13. The 6/18/13 meeting had minutes submitted 6/24/13 (is within 5 working days). The plan responded to timeliness of submission of the minutes, indicating that they had had a discussion with DHH to submit minutes quarterly. DHH indicated in May 2013, that the minutes should be submitted within 5 business days, and the health plan now submits minutes within 30 business days. The plan also noted that Amendment 3, currently in draft, has a provision to delete those clauses from the contract. The plan did submit minutes after May, 2013 within the timeframe of the contract.	MCO response: As indicated in the auditor's comments, submission of QAPI Committee minutes within 5 business days is already part of the QAPI Program's standard process. IPRO response: Determination is unchanged. While policy includes the timeliness provision, file review indicated that some were not delivered within the timeframe specified. File review will be conducted as part of next year's audit to assess whether the time frame standard is met.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.8.2	QAPI Plan - The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic division provided by the governing body. The QAPI plan shall be submitted to DHH for written approval within thirty (30) date the Contract is signed, annually thereafter, and prior to revisions. The QAPI plan shall:	Full	2012 UHCLA QI Program Description describes the plan's written plan. UHC SQ121 QAPI Program Description describes that a QAPI plan has been developed and describes the governing body and has documentation of annual submission and prior to admissions. NQM-Policy-048 Quality Improvement Program addresses the governing body of the program. LA 2012 QI Workplan was reviewed. There is no evidence of it being updated or signed. UHC SQ121 QAPI Workplan was reviewed. DHH confirmed receipt as per contract requirements.	
7.1.8.2.0.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	Full	LA 2012 QI Workplan includes planning, decision making, interventions and assessment of results. UHC SQ121 QAPI Workplan includes planning, decision making, interventions and assessment of results.	
7.1.8.2.0.2	Include a description of the CCN staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and	Full	2012 UHCLA QI Program Description addresses these contract requirements. UHC SQ121 QAPI Program Description addresses these contract requirements. LA 2012 QI Workplan includes the department assigned to each project in the work plan. UHC SQ121 QAPI Workplan includes the department title for each project in the work plan.	
7.1.8.2.0.3	Describe the role of its providers in giving input to the QAPI Program.	Full	2012 UHCLA QI Program Description meets this requirement. UHC SQ121 QAPI Program Description meets this	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			requirement.	
7.1.8.2.1	QAPI Reporting Requirements - The CCN shall submit QAPI reports annually to DHH. DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports. The QAPI reports shall contain at a minimum:	Full	2012 UHCLA QI Program Description indicates an annual report is submitted to DHH. UHC SQ121 QAPI Program Description describes an annual report will be submitted to DHH. UHC SQ216A QAPI impact and effectiveness of QAPI program evaluation addresses this requirement.	
7.1.8.2.1.0.1	Quality improvement (QI) activities;	Full	UHC SQ121 QAPI Program Description describes an annual report will be submitted to DHH and contain this contract requirement. UHC SQ216A QAPI Impact and Effectiveness of QAPI Program Evaluation addresses this requirement. UHC SQ216A QAPI impact and effectiveness of QAPI program evaluation addresses this requirement.	
7.1.8.2.1.0.2	Recommended new and/or improved QI activities; and	Full	UHC SQ121 QAPI Program Description describes an annual report will be submitted to DHH and contain this contract requirement. UHC SQ216A QAPI Impact and Effectiveness of QAPI Program Evaluation identified and recommended opportunities for improvement based on monitoring activity.	
7.1.8.2.1.0.3	Evaluation of the impact and effectiveness of the QAPI program.	Full	UHC SQ121 QAPI Program Description describes an annual report will be submitted to DHH and contain this contract requirement. UHC SQ216A QAPI Impact and Effectiveness of QAPI Program Evaluation addresses this requirement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.8.3	The CCN shall participate in the Department's quality committee.	Full	2012 UHCLA QI Program Description meets this requirement. UHC SQ121 QAPI Program Description meets this requirement.	
7.1.8.4	The CCN will agree to an External Quality Review, review of the Quality Assessment Committee meeting minutes, and annual medical audits to ensure that CCN providers provide quality and accessible health care to CCN members, in accordance with standards contained in this RFP and under the terms of this RFP. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to surveys and other information concerning the use of services and the reasons for member disenrollment.	Full	UHC SQ121 QAPI Program Description describes that the plan will "Ensure that reporting systems provide appropriate information for meeting the requirements of external regulatory review and accrediting bodies." Plan provided response to this contract requirement: "these standards reference participation in EPRO audits and corrective action plans. The first EQRO audit is currently in progress. No corrective action plans regarding Quality Program have been issued to date. EQRO audit verifies compliance.	
7.1.8.5	It is agreed that the standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to DHH prior approval.	Full	NQM-Policy-048 Quality Improvement Program addresses these requirements. There has been no CAP requested.	
7.1.8.6	In the event the CCN fails to complete the actions required by	N/A	P/P NQM-048 The Quality Improvement Program states that corrective action plans must be developed in a	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the CAP, the CCN agrees that DHH may assess the monetary penalties specified in this RFP. The CCN further agrees that any monetary penalties assessed by DHH will be due and payable to DHH immediately upon notice. If payment is not made by the due date, said monetary penalties may be withheld from future enhanced primary care case management fee payments by DHH without further notice.		timely manner to avoid possible penalties or sanctions. The plan has indicated they have never had to complete a Corrective Action Plan as this is the first audit.	
7.1.8.7	The CCN is required to conduct performance improvement projects as specified in this RFP.	Full	UHC SQ121 QAPI Program Description addresses this requirement. It should be noted that the plan refers to performance improvement projects interchangeable with quality improvement projects. P/P NQM-049 Quality Improvement Projects addresses this requirement. P/P NQM-021 Evaluation of Interventions in QIPs addresses this requirement. 2012 Quality Improvement Program Evaluation addresses this requirement and reports the PIPs that are currently in progress. Performance Improvement Projects were reviewed and have been submitted and being conducted as required.	
7.1.9	**Performance Measures**			
7.1.9.1	The CCN shall report clinical and administrative performance measure (PM) data, as specified by DHH and in accordance with the	Full	P/P NQM-048 The Quality Improvement Program addresses the policy for reporting performance measures.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	specifications of the CCN Quality Companion Guide.		UHC SQ121 QAPI Program Description addresses this contract requirement. 2012 Quality Improvement Program Evaluation reports that HEDIS and CAHPS data were not reported; however the data available and opportunities for improvement will be evaluated and fully implemented in 2013. Plan provided a response with the submission of documentation that states because their contract began 2/1/12, PMs were not due to be reported during the audit timeframe. Administrative PMs are Early Warning Systems and have been reported as required.	
7.1.9.2	The CCN is required to report on PMs listed in Appendix H which include, but are not limited to, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consume Assessment of Healthcare Providers and Systems (CAHPS) measures, and/or other measures as determined by DHH.	Full	P/P NQM-010 Supplemental Electronic Data for Input into HEDIS Repository addresses CCN requirement for HEDIS. P/P NQM-048 The Quality Improvement Program addresses reporting of performance measures. UHC SQ121 QAPI Program Description addresses this contract requirement. 2012 Quality Improvement Program Evaluation reports that HEDIS and CAHPS data were not reported; however the data available and opportunities for improvement will be evaluated and fully implemented in 2013.	
7.1.9.3	The CCN shall have processes in place to monitor and self-report all performance measures.	Full	2012 Quality Improvement Program Evaluation reports that HEDIS and CAHPS data were not reported; however the data available and opportunities for improvement will be evaluated and fully implemented in 2013.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			UHC SQ 121 QAPI Workplan 2013 addresses this requirement. Target completion is Summer 2013.	
7.1.9.4	Clinical PM outcomes shall be submitted to DHH annually and upon DHH request.	N/A	2012 Quality Improvement Program Evaluation states that the plan has indicated that because their contract began 2/1/2012 clinical performance measures were not due during this audit timeframe.	
7.1.9.5	Administrative PMs shall be submitted to DHH semiannually and upon DHH request.	Full	2012 Quality Improvement Program Description addresses PMs. UHC SQ121 QAPI Workplan 2013 addresses schedule of PMs. Early Warning System Performance Measures are being reported as specified by DHH.	
7.1.9.6	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	N/A	2012 Quality Improvement Program Evaluation states that the plan has indicated that because their contract began 2/1/2012 clinical performance measures were not due during this audit timeframe.	
7.1.10	**Early Warning System Performance Measures**			
7.1.10.0	The CCN shall collect and report monthly on the Early Warning System Performance Measure outcomes, as specified by DHH in this RFP (Appendix H), in order to monitor and evaluate the successful implementation of the CCN program. During a CCN's first two years of operations, distribution of any savings will be contingent upon the CCN meeting the established "Early Warning System" performance measures and compliance under	Full	Attestations and Monthly reports were provided for review, indicating this requirement is being met: UHC SQ217 QAPI Early Warning Systems Performance Measures 201ymm AT.xls, addresses this requirement. Plan indicated that this is exercised at DHH's discretion. There is no deliverable.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	this Contract. After the second year of operations, distribution of any savings will be contingent upon the CCN meeting established performance measures and compliance with this Contract.			
7.1.11	**Incentive-based Measures**			
7.1.11.1	Incentive Based (IB) measures are Level I measures that may affect savings payments and can be identified in Appendix H with "$".	N/A	USCMM 02 12 Performance Assessment and Incentives addresses incentives, but doesn't specify Level I measures. The plan states that Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012 therefore not applicable during the audit timeframe.	
7.1.11.2	A maximum of 100% eligible (20% for each of the 5 Incentive Based Performance Measures) savings payout will be contingent upon the CCN's Performance Measure outcomes for CYE 12/31/2013 or otherwise specified by DHH. All Incentive Based and Level I performance measures that fall below performance standards will require a corrective action plan (CAP) (See Appendix H).	N/A	UHC SQ 121 QAPI Workplan addresses this requirement. Target date is Summer 2013 as specified by EQRO. Not applicable during the audit timeframe.	
7.1.11.3	DHH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and DHH will provide sixty (60) days	N/A	The plan states "DHH has not made any changes to date."	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	notice of such change.			
7.1.12	**Reporting Measures**			
7.1.12.1	All Administrative, Level I and Level II PMs are reporting measures.	N/A	Appendix H: Louisiana Administrative Performance Measure Set identifies Administrative PM Set which includes the Early Warning System Performance Measures, Level I and Level II Measures that are request for proposals. The plan did report that the contract began 2/1/12 and therefore these reporting measures have not yet been done and this does not apply for this contract period.	
7.1.12.2	Administrative measure reporting is required semiannually and upon DHH request.	Full	2013 Quality Improvement Program Description describes being reported in the Work Plan and the annual Program Evaluation. LA 2012 QI Work Plan addresses this requirement and indicates these measures will be reported in 2013. UHC SQ217 QAPI Early Warning Systems Performance Measures are being reported as specified by DHH. Attestations were supplied and indicate compliance.	
7.1.12.3	Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.	N/A	LA 2012 QI Work Plan addresses this requirement and indicates these measures will be reported in 2013. The plan did report that the contract began 2/1/12 and therefore this contract provision does not apply for this contract period.	
7.1.12.4	Prevention Quality Indicator measures within Level I shall be reported quarterly and upon DHH request beginning in 2014 utilizing CY 2013 data for Contracts that begin after January 1, 2012.	N/A	LA 2012 QI Work Plan addresses this requirement and indicates these measures will be reported in 2013. The plan did report that the contract began 2/1/12 and therefore this contract provision does not apply for this contract period.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.12.5	Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2013 utilizing CY 2012 data for Contracts that begin January 1, 2012.	N/A	UHC SQ121 QAPI Work plan addresses this requirement. It is identified as being targeted for the summer of 2013. The plan did report that the contract began 2/1/12 and therefore these reporting measures have not yet been done and this does not apply for this contract period. LA 2012 QI Work Plan addresses this requirement and has it targeted for 2013.	
7.1.12.6	Level I and Level II measure reporting is required annually, and upon DHH request, beginning in 2014 utilizing CY 2012 data for Contracts that begin after January 1, 2012.	N/A	UHC SQ121 QAPI Work plan addresses this requirement. It is identified as being targeted for the summer of 2013. The plan did report that the contract began 2/1/12 and therefore these reporting measures have not yet been done and this does not apply for this contract period. LA 2012 QI Work Plan addresses this requirement and has it targeted for 2013.	
7.1.12.7	DHH may add or remove PM reporting requirements with a sixty (60) day advance notice.	N/A	At the discretion of the DHH. There is no deliverable for this as per the plan.	
7.1.13	**Performance Measure Goals**			
7.1.13.1	The Department will establish benchmarks for Incentive Based and Level I Performance measures utilizing statewide data of the Medicaid Fee for Service Population for CY 2011 with the expectation that performance improves by a certain percentage.	N/A	State benchmarks were received on 7/1/13, outside of the audit timeframe. The QAPI Work Plan has been updated to include these State benchmarks, although this did occur outside of the audit timeframe.	
7.1.13.2	Statewide goals will be set for 2015 Level II Performance Measures utilizing an average of all CCNs' outcomes received in 2014 for the	N/A	Not applicable during the audit timeframe.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	2013 measurement year.			
7.1.14	**Performance Measure Reporting**			
7.1.14.1	The CCN shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	Full	NQM-003 HEDIS Data Auditing and NQM-010 HEDIS Supplemental Electronic Data for Input into HEDIS Repository address these requirements.	
7.1.14.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by DHH.	Full	NQM-003 HEDIS Data Auditing addresses these requirements.	
7.1.14.3	The CCN shall have processes in place to monitor and self-report performance measures as specified in §16, Reporting Measures using DHH specified requirements and format. The CCN shall provide individual PCP clinical quality profile reports as indicated specified by DHH.	Full	UHC SQ121 QAPI Program Description addresses this requirement regarding having processes in place and the provision of individual PCP clinical quality profile reports however there is no specification regarding DHH's role in the process. The plan indicated that Performance measure reporting has not yet been specified by DHH.	
7.1.15	**Performance Measure Monitoring**			
7.1.15.1	DHH will monitor the CCN's performance using Benchmark Performance and Improvement Performance data.	N/A	UHC SQ121 QAPI Work plan addresses developing Benchmark performance and Improvement Performance data for 6/30/13. LA 2012 QI Work Plan addresses this requirement for the future. Not applicable during the audit timeframe.	
	During the Contract, DHH or its designee will actively participate with the CCN to review the results of performance measures.	N/A	UHC SQ121 QAPI Work plan addresses developing Benchmark performance and Improvement Performance data for 6/30/13.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			LA 2012 QI Work Plan addresses this requirement for the future. Not applicable during the audit timeframe.	
7.1.15.3	The CCN shall comply with External Quality Review, review of the Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to CCN members, in accordance with standards contained in the Contract. Such audits shall allow DHH or its duly authorized representative to review individual medical records, identify and collect management data, including but not limited to, surveys and other information concerning the use of services and the reasons for member disenrollment.	Full	2012 Quality Improvement Program Description addresses this requirement. Not applicable during the audit timeframe. It should be noted that the plan fully complied with this EQRO audit.	
7.1.15.4	The standards by which the CCN will be surveyed and evaluated will be at the sole discretion and approval of DHH. If deficiencies are identified, the CCN must formulate a Corrective Action Plan (CAP) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The CAP is subject to approval by DHH. DHH will monitor the CCN's progress in correcting the deficiencies.	N/A	2012 Quality Improvement Program Description addresses this requirement. Not applicable during the audit timeframe.	
7.1.16	**Corrective Action Plan**			

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.16.0	A corrective action plan (CAP) will be required for performance measures that do not reach the Department's performance benchmark.	N/A	Policy NQM-048 Quality Improvement Program Policy addresses this contract requirement. No CAP has been required to date.	
7.1.16.1	The CCN shall submit a CAP, within thirty (30) calendar days of the date of notification or as specified by DHH, for the violation or noncompliance specified by DHH.	Full	Policy NQM-048 Quality Improvement Program Policy addresses this requirement. No CAP has been required to date.	
7.1.16.2	Within thirty (30) calendar days of receiving the CAP, DHH will either approve or disapprove the CAP. If disapproved, the CCN shall resubmit, within fourteen (14) calendar days, a new CAP that addresses the concerns identified by DHH.	N/A	Policy NQM-048 Quality Improvement Program Policy addresses this requirement, however does not specifically address the timeframes of the contract. No CAP has been required to date.	
7.1.16.3	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.	Full	Policy NQM-048 Quality Improvement Program Policy addresses this requirement. No CAP has been required to date.	
7.1.16.4	DHH may impose monetary penalties, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.	N/A	No CAP has been required to date.	
7.1.17	**Performance Improvement Projects**			
7.1.17.1	The CCN shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focus on clinical and non-clinical performance measures.	Full	2012 UHCLA QI Program Description describes the establishment and implementation of PIPs as described in the contract requirement: Increasing the Rate of Breast Cancer Screening submitted 4/30/12.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			Reducing Emergency Department Visits for Children with Asthma submitted 4/30/12. NQM-049 Quality Improvement Projects addresses this requirement.	
7.1.17.2	The CCN shall perform a minimum of two (2) DHH approved PIPs in the first Contract year. The DHH required PIP during the first Contract year is listed in Section 1 of Appendix V - Performance Improvement Projects. The CCN shall choose the second PIP from Section 2 of Appendix V. DHH may require an additional PIP each successive year to reach a maximum of four (4) PIPs.	Full	Appendix V-Performance Improvement Projects address this requirement. LA 2012 QI Work Plan addresses this requirement. UHC SQ121 QAPI Workplan addresses this requirement. PIPS were reviewed and meet contract requirements.	
7.1.17.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each PIP must involve the following: a. Measurement of performance using objective quality indicators; b. Implementation of system interventions to achieve improvement in quality; c. Evaluation of the effectiveness of the interventions; and d. Planning and initiation of activities for increasing or sustaining improvement.	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement. LA 2012 QI Work Plan addresses this requirement. PIPS were reviewed and met contract requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.17.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the CCN shall submit, in writing, a general and a detailed description of each PIP to DHH for approval. The detailed PIP description shall include: a. An overview explaining how and why the project was selected, as well as its relevance to the CCN members and providers; b. The study question; c. The study population; d. The quantifiable measures to be used, including a goal or benchmark; e. Baseline methodology; f. Data sources; g. Data collection methodology and plan; h. Data collection cycle; i. Data analysis cycle and plan; j. Results with quantifiable measures; k. Analysis with time period and the measures covered; l. Analysis and identification of opportunities for improvement; and m. An explanation of all interventions to be taken.	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement. PIPS were reviewed and met contract requirements.	
7.1.17.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and /or flow charts) for monitoring and shall: a. Target specific conditions and specific health service delivery	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	issues for focused system-wide and individual practitioner monitoring and evaluation; b. Use clinical care standards and/or practice guidelines to objectively evaluate the care the CCN delivers or fails to deliver for the targeted clinical conditions; c. Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; d. Implement system interventions to achieve improvement in quality; e. Evaluate the effectiveness of the interventions; f. Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; g. Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; h. Reflect the population served in terms of age groups, disease categories, and special risk status, i. Ensure that appropriate health professionals analyze data; j. Ensure that multi-disciplinary teams will address system issues; k. Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark;		PIPs were reviewed and met contract requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	l. Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and m. Maintain a system for tracking issues over time to ensure that actions for improvement are effective.			
7.1.17.6	DHH, in consultation with CMS and other stakeholders, may require specific performance measures and topics for performance improvement projects. The CCN shall report the status and results of each PIP as specified in the Quality Companion Guide. a. If CMS specifies Performance Improvement Projects, the CCN will participate and this will count toward the State-approved PIPs.	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement. The plan has been compliant with reporting the status and results of each PIP as required.	
7.1.17.7	Each Performance Improvement Project shall be completed in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement. The plan response was provided with submission of files and states that only an initial proposal was due during the audit timeframe. Due to the time cycle for the calculation of HEDIS measures, there were no PMs available to evaluate the effectiveness of interventions.	
7.1.18	**PIP Reporting Requirements**			

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.18.1	The CCN shall submit PIP outcomes annually to DHH.	Full	NQM-021 Evaluation of Interventions in Quality Improvement Projects addresses this requirement. NQM-049 Quality Improvement Projects addresses this requirement.	
7.1.18.2	Reporting specifications are detailed in the Quality Companion Guide.	Full	Policy NQM-049 Quality Improvement Projects includes a QIP form, but the policy also makes allowances for State mandated forms. The Louisiana plan uses the State mandated IPRO form for its PIPs.	
7.1.18.3	DHH reserves the right to request additional reports as deemed necessary. DHH will notify the CCN of additional required reports no less than thirty (30) days prior to due date of those reports.	N/A	CCN responded with "This is at the discretion of the DHH."	
7.1.19	**Member Advisory Council**			
7.1.19.0	The CCN shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs. The Council is to be chaired by the CCN's Administrator / CEO / COO or designee and will meet at least quarterly. Every effort shall be made to include a broad representation of both members / families / significant others, member advocacy groups and providers that reflect the population and community served. Members / families / significant	Full	2012 Quality Improvement Program Description defines the Member Advisory Council as documented in the contract requirements. LA Member Advisory Charter defines the purpose, overview, scope, advisory council structure, advisory council members, and meeting guidelines. Meeting agendas indicate the meeting is chaired by the Member Service Manager who is also known as Director, Community Relations, UHC Community Plan Louisiana. 2013 Member Advisory Council Schedule has monthly meeting scheduled alternating at 3 locations meeting the 3 serviced regions. Quarterly minutes for Member Advisory Council was submitted for review and meet contract requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.			
7.1.19.1	The CCN shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Full	Member Advisory Committee PowerPoint was available for review. Quarterly minutes submitted validated that the contract requirements were met.	
7.1.19.2	The CCN shall develop and implement a Member Advisory Council plan that outlines the schedule of meetings and the draft goals for the council that includes, but not limited to, member's perspectives to improve quality of care. This plan shall be submitted to DHH within thirty (30) days of signing the contract and annually thereafter by December 15h.	Full	LA Member Advisory Charter defines the purpose, overview, scope, advisory council structure, advisory council members, and meeting guidelines. DHH verified submission within contract requirements.	
7.1.19.3	DHH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the CCN website.	Substantial	LA Member Advisory Charter defines the purpose, overview, scope, advisory council structure, advisory council members, and meeting guidelines. A Plan Response included in the files submitted reported that the DHH representatives are included in all correspondence regarding Member Advisory Council Meetings and are invited to attend each meeting. Agendas and minutes are submitted to DHH. The CCN's website located at www.uhccommunityplan.com is currently undergoing server maintenance with an anticipated completion date of October, 2013. Following this scheduled upgrade, the CCN will make the Member Advisory Council meeting agendas and minutes available on its website.	MCO response: Member Advisory Council meeting agendas and minutes are now posted to the website. IPRO response: Determination is unchanged. Completion of the server upgrade and posting of meeting agendas is noted and will be reviewed again as part of next year's audit.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.19.4	A representative of the Member Advisory Council shall participate on the DHH CCN Member Advisory Committee.	Full	2012 Quality Improvement Program Description addresses this contract requirement. A Plan Response submitted with the files stated that at this time the CCN is clarifying the existence of Louisiana's Department of Health and Hospitals (DHH) Coordinated Care Networks (CCN) Member Advisory Committee. Upon clarification and/or creation of such a committee, UHC will nominate a member of its Member Advisory Council to serve as a representative.	
7.1.20	**Member Satisfaction Surveys**			
7.1.20.1	The CCN shall conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and utilize methodology to assess the quality and appropriateness of care to members.	Full	Member and Provider Satisfaction Surveys were performed and results presented: UHC_2013_CAHPS_Child.pdf (all) UHC_2013_CAHPS_Adult.pdf (all) ucp7_CAHPS_ChildCCC_2013.pdf ucp3_CAHPS_Adult_2013.pdf	
7.1.20.2	The CCN shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. a. The CCN's vendor shall perform CAHPS Adult surveys, CAHPS Child surveys, and CAHPS Children with Chronic Conditions survey.	Full	The vendor performing the CAHPS surveys is: Center for the Study of Services PO Box 10810 Herndon, VA 20172-9904	
7.1.20.3	Survey results and a description of the survey process shall be reported to DHH separately for each required CAHPS survey.	Full	Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Adult Medicaid Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement. Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Child Medicaid with CCC Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.1.20.4	The CAHPS survey results shall be reported separately for each CCN GSA. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the CCN at the time of the survey.	Full	Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Adult Medicaid Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement. Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Child Medicaid with CCC Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement.	
7.1.20.5	The surveys shall provide valid and reliable data for results in the specific CCN GSA.	N/A	GSA reporting not required.	
7.1.20.6	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	Full	Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Adult Medicaid Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement. Report of Results of UHC of La 2013 HEDIS/CAHPS Health Plan Survey Child Medicaid with CCC Version for Medicaid Members Enrolled as of December 31, 2012 addresses this requirement.	
7.1.20.7	The most current CAHPS Health Plan Survey (currently 4.0) for Medicaid Enrollees shall be used and include: a. Getting Needed Care b. Getting Care Quickly c. How Well Doctors Communicate d. Health Plan Customer Service e. Global Ratings	Full	Most current CAHPs Health Plan Survey addresses these requirements.	
7.1.20.8	Member Satisfaction Survey Reports are due one hundred and twenty (120) days after the end of the plan year.	N/A	The CCN indicated that the DHH modified the due date to August 30, 2013 to accommodate the standard NCQA CAHPs cycle. It was submitted to the State on 8/30/13. This is not in the contract year being reviewed at this time.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			It should be noted this document was available for review and submitted as requested by DHH.	
7.1.21	**Provider Satisfaction Surveys**			
7.1.21.1	The CCN shall conduct an annual provider survey to assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims preprocessing, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation.	Substantial	UnitedHealthcare of Louisiana - 2012 Physician Scorecard reviewed did not address medical reviews or support towards a patient-centered medical home. All other contract requirements were included in the survey.	MCO response: Format has been changed to add support of PCMH and ease of medical reviews. IPRO response: Determination is unchanged. Updated scorecard will be reviewed as part of next year's audit.
7.1.21.1.1	The Provider Satisfaction survey tool and methodology must be submitted to DHH for approval prior to administration.	Full	2012 Provider Satisfaction survey and tool met contract requirements. 2013 Provider Satisfaction Survey is still being developed.	
7.1.21.2	The CCN shall submit an annual Provider Satisfaction Survey Report that summarizes the survey methods and findings and provides analysis of opportunities for improvement. Provider Satisfaction Survey Reports are due one-hundred and twenty (120) days after the end of the contract year.	Full	2012 UHC Physician Satisfaction Results were provided and reviewed.	
7.1.22	**DHH Oversight of Quality**			
7.1.22.0	DHH shall evaluate the CCN's QAPI, PMs, and PIPs at least one (1) time per year at dates to be determined by DHH, or as otherwise specified	N/A	NQM-049 Quality Improvement Project addresses annual review by the State. There is no documentation regarding consequences or evaluation as stated in contract requirements.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	by the Contract. If DHH determines that the CCN's quality performance is not acceptable, DHH will require the CCN to submit a corrective action plan (CAP) for each unacceptable performance measure. If the CCN fails to provide a CAP within the time specified, DHH will sanction the CCN in accordance with the provisions of sanctions set forth in the Contract, and may immediately terminate all new enrollment activities and automatic assignments. Upon any indication that the CCN's quality performance is not acceptable, DHH may restrict the CCN's enrollment activities including, but not limited to, termination of automatic assignments. When considering whether to impose a limitation on enrollment activities or automatic assignments, DHH may take into account the CCN's cumulative performance on all quality improvement activities. The CCN shall cooperate with DHH, the independent evaluation contractor (External Quality Review Organization), and any other Department designees during monitoring.		2012 Quality Improvement Program Description indicated maintenance of compliance with local, state and federal regulatory requirements and accreditation standards. It is suggested that the CCN add the contract language as specified.	
7.1.22.1	External Independent Review	N/A		
7.1.22.1.1	The CCN shall provide all information requested by the	N/A	This did not occur during the contract timeframe.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.		It should be noted the CCN cooperated with the EQRO during the annual review.	
7.1.22.1.2	The CCN shall cooperate with the EQRO during the review (including medical record review, which will be done at least one (1) time per year.	N/A	This did not occur during the contract timeframe. It should be noted the CCN cooperated with the EQRO during the annual review.	
7.1.22.1.3	If the EQRO indicates that the quality of care is not within acceptable limits set forth in the Contract, DHH may sanction the CCN and may immediately terminate all enrollment activities and automatic assignment until the CCN attains a satisfactory level of quality of care as determined by the EQRO.	N/A	This did not occur during the contract timeframe.	
7.1.22.1.4	A description of the performance improvement goals, objectives, and activities developed and implemented in response to the EQR findings will be included in the Contractor's QAPI program. DHH may also require separate submission of an improvement plan specific to the findings of the EQR.	N/A	This did not occur during the contract timeframe.	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
7.0	**Enhanced Primary Care Case Management Services**			
	Credentialing and Re-credentialing of Providers and Clinical Staff			
	The CCN must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12; §438.206, §438.214, §438.224 and §438.230 and NCQA health plan Accreditation Standards for the review and credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship.	Full	Addressed in P/P Credentialing and Recredentialing Plan. Attachment E - State and Federal Regulatory Addendum, provided for review. <u>Credentialing File Review: Recredentialing (Total files reviewed: 8)</u> 4 files contained a copy of the provider's state license; however, Aperture Credentialing, Inc. source verified up-to-date licenses for all files. 2 files contained an expired board certification. 3 providers were not board certified and application indicated that the provider had no intention of becoming board certified. 4 files did not contain signed and dated Attestations. Discussion with the plan indicated that the signed attestation was not required during every Recredentialing application. The providers are responsible only for updating information that has changed as part of the Recredentialing process. None of the files reviewed showed any of the providers having Medicare or Medicaid sanctions. Two providers had professional liability claims within the past 5 years. Written notification of Recredentialing status was not	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			submitted for 8 files. The plan stated that written notification is only given if the application is denied.	
	The CCN shall use the state's standardized credentialing form (see Appendix F – Louisiana Standardized Credentialing Application Form).	Full	Attachment E - State and Federal Regulatory Addendum, states "Accept either the Louisiana (LA) Standardized Credentialing Application form, or its successor, or the current form used by the Council for Affordable Quality Healthcare (CAQH)". All files reviewed contained a standardized credentialing application form.	
	An independent relationship exists when the CCN selects and directs it members to see a specific provider or group of providers.	N/A	Credentialing and Recredentialing Plan provided for review. States "All Licensed Independent Practitioners and Facilities that the Credentialing Entity names as part of its Network, including Leased Networks, as required by Credentialing Authority are subject to the Credentialing Plan." Found in Section 2.0 Definitions that an independent relationship exists for practitioner who provides care under a Benefits Plan.	
	These procedures shall be submitted as part of the Proposal, when a change is made, and annually thereafter.	N/A		
	The process for periodic re-credentialing shall be implemented at least once every three (3) years.	Full	Contained in Credentialing and Recredentialing Plan – Section 5.1 Recredentialing of Participating LIPSs: Application. <u>Credentialing File Review: Recredentialing (Total files reviewed: 8)</u> Of the 8 re-credentialing files reviewed all applications were approved and recredentialed within 3 years.	
	If the CCN is not NCQA health plan accredited and has delegated	Full	Addressed in P/P Credentialing and Recredentialing Plan	

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.		Addressed in P/P DelCredOversight. Credentialing and Recredentialing Plan states "Any delegation of responsibility by the Credentialing Entity must be evidenced by a Credentialing Delegation Agreement that requires compliance with Credentialing Authorities." File review found UHC-LA uses Aperture Credentialing, Inc. to complete credentialing.	
	If the CCN has NCQA health plan Accreditation those credentialing policies and procedures shall meet DHH's credentialing requirements.	N/A	UHC-LA not yet NCQA Accredited.	
	The CCN shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	Substantial (determination changed to "Full")	Addressed in P/P Credentialing and Recredentialing - Section 4.0 Initial Credentialing of Licensed Independent Practitioner Applicants. Language regarding the board certification status of LIPs is only addressed in terms of initial credentialing. <u>Credentialing File Review: Initial (Total files reviewed: 2)</u> Of the two initial credentialing files reviewed, 1 application was denied. This denial was due to the fact that the plan was unable to verify completion of a residency or fellowship in the provider's practicing specialty. Written notification of the denial was sent to the provider. 2 files reviewed contained up-to-date state licenses and DEA certificates. UHC-LA uses Aperture Credentialing, Inc.	MCO response: UHC's Credentialing Plan, Section 4.2 paragraph 1, requires primary source verification of board certification if applicable. Section 5.2, paragraph 1, requires all applicants to meet the initial credentialing criteria as set forth in Section 4.2 at the time of recredentialing. UHC requests considering updating this rating to Full. IPRO response: Review determination changed to "Full" based on a re-review of the credentialing policy.

Enhanced Primary Care Case Management (PCCM)				
State Contract Requirements [Federal Regulation: 438.114, 438.206, 438.208, 438.210, 438.214, 438.236, 438.240, 438.404]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
			(OptumInsight) to complete primary source verification. Site visits were not performed or required.	
	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	Addressed in P/P NQM-023 Suspension or Termination of a Provider (approved on July 25, 2012). Addressed in P/P NQM-004 QOC Concerns.	
	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 P/P NQM-023 Suspension or Termination of a Provider. This document most recently approved on July 25, 2012. Document was previously reviewed on 10/07, 10/08, 6/10 and 7/11.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1	**Assurance of Adequate Access and Capacity**			
8.1.1	Access to PCPs	N/A		
8.1.1.1	The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Clinic) or outpatient clinic. The CCN shall agree to provide at least one (1) full-time equivalent (FTE) PCP per twenty-five hundred (2,500) CCN members. The CCN shall ensure each individual PCP shall not exceed a linkage total of 2,500 Medicaid eligibles across all CCN's in which the PCP may be a network provider.	Full	Addressed in Network Development and Management Plan 11.16.11; and Managed Care Accessibility Analysis 7.20.12, 10.24.12, 1.19.13 and 7.19.13.	
8.1.1.2	The CCN may, at its discretion, allow vulnerable populations (for example persons with multiple disabilities, acute, or chronic conditions, as determined by the CCN) to select their attending specialists as their PCP so long as the specialist is willing to perform responsibilities of a PCP and become a network provider for the CCN.	Full	Addressed in Network Development and Management Plan 11.16.11.	
8.1.1.3	The CCN shall provide access to primary care providers that offer extended office hours (minimum of 2 hours) at least one day per week (after 5:00 pm) and on Saturdays [four (4) hours or longer]. Network providers must offer office hours at least equal to those offered to the CCN's Medicaid fee-for-service participants, if the provider accepts only Medicaid patients.	Full	Addressed in Network Development and Management Plan 11.16.11.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.1.1.4	The CCN shall identify and report to the Enrollment Broker, within seven (7) calendar days, any PCP approved to provide services under the Contract that will not accept new patients or has reached capacity.	Full	Addressed in Network Development and Management Plan 11.16.11.	
8.2	**Full-time Definition**			
8.2.0	DHH defines a full time PCP as a provider that provides primary care services for a minimum of twenty (20) hours per week of practice time.	N/A		
8.3	**PCP/Member Ratio**			
8.3.0	The PCP to Medicaid member patient ratio (inclusive of all CCN members) shall not exceed the following unless approved in writing by DHH: Physician (Family Practice, General Practice, Internal Medicine Pediatric, OB/GYN) 1: up to 2,500; Nurse Practitioner (not linked to a physician group) 1: up to 1,000; Physician with physician extenders (Nurse Practitioner/Physician Assistant; and Certified Nurse Midwife for OB/GYNs only) may increase basic physician ratio of 1: up to 2,500 by 1,000 per extender.	Full	Addressed in QMP 001 – UHC Louisiana – Rider.	
8.4	**Travel Time and Distance**			
8.4.0	The CCN shall comply with the following maximum travel time and/or distance requirements, as determined by mapping software (e.g. MapQuest, Google Maps). Requests for exceptions as a result	Full	Addressed in QMP 001 – UHC Louisiana – Rider	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of prevailing community standards must be submitted in writing to DHH for approval. The CCN shall ensure that in accordance with usual and customary practices primary care provider services are available on a timely basis.			
8.4.1	Access to Primary Care Providers - travel distance for members living in rural parishes shall not exceed 30 miles; and travel distance for members living in urban parishes shall not exceed 20 miles. Services are considered accessible if they reflect usual practice and travel arrangements in the local area. Exceptions may be approved, by DHH, if the travel distance for medical care exceeds these requirements.	Full	Addressed in QMP 001 – UHC Louisiana – Rider.	
8.5	**Scheduling/Appointment Waiting Times**			
8.5.1	The CCN shall ensure that its network providers have an appointment system for primary care services which is in accordance with prevailing medical community standards as specified below.	N/A		
8.5.2	The CCN shall have policies and procedures for these appointment standards. Methods for educating both the providers and the members about appointment standards shall be addressed in these policies and procedures. The CCN shall disseminate these appointment standard policies and procedures to its in-network	Full	Addressed in QMP 002 – UHC Louisiana Rider; Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook; UnitedHealthcare Community Plan Member Handbook; 2012 Appointment Availability Survey Results; 2012 After-Hours Accessibility Survey Results; 121211_QMC_Signed_Minutes; 121218_QMC_Signed_Minutes; and 130123_QMC_Signed_Minutes.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	providers and to its members. The CCN shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.		Although the appointment standards are printed in the Provider Manual and Member Handbook, the policy and procedure does not include language on how members and providers will be educated about the appointment standards.	
8.6	**Timely Access**			
8.6.1	The CCN shall ensure that medically necessary services are available on a timely basis, as follows: emergent or emergency visits immediately upon presentation at the service delivery site; urgent care within twenty-four (24) hours; non-urgent sick care within seventy-two (72) hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition; routine, non-urgent, or preventative care visits within six (6) weeks;	Full	Addressed in QMP-002.	
8.6.2	The CCN shall strive to achieve the following timeframes through the development of partnerships/relationships with FFS providers: specialty care consultation within one (1) month of referral or as clinically indicated; lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and forty-eight (48) hours for urgent care or as clinically indicated; and	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
8.6.3	Follow-up visits in accordance with ER attending provider discharge instructions.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	

Service Accessibility Standards				
State Contract Requirements [Federal Regulation: 438.206, 438.207]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
8.7	**Maternity Care**			
8.7.1	The CCN shall work with FFS provider to try to achieve the following:	N/A		
8.7.1.1	An initial appointment for prenatal visits for newly enrolled pregnant women within the following timetables from the postmark date the CCN mails the member's welcome packet: within their first trimester within fourteen (14) days; within the second trimester with seven (7) days; within their third trimester within three (3) days; and high risk pregnancies within three (3) days of identification of high risk by the CCN or maternity care provider, or immediately if an emergency exists;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook. Onsite Interview Response: Non clinical team reaches member specifically asking about accessing prenatal care. If the member has prenatal care in place, we document it. If not, we offer to find a provider and schedule an appointment.	
8.7.2	Initial appointment for CCN members who become pregnant shall be within forty-two (42) days.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook. Onsite Interview Response: Non clinical team reaches member specifically asking about accessing prenatal care. If the member has prenatal care in place, we document it. If not, we offer to find a provider and schedule an appointment. We also educate providers on related HEDIS measures.	

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

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	Contract Requirement Language	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	MCO Response and Plan of Action
9.4.1.4	Emergency service responsibilities;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.5	Policies and procedures that cover the provider complaint system. This information shall include, but not be limited to, specific instructions regarding how to contact the CCN to file a provider complaint and which individual(s) has the authority to review a provider complaint;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.6	Information about the CCN's Grievance System, that the provider may file a grievance or appeal on behalf of the member, the time frames and requirements, the availability of assistance in filing, the toll-free telephone numbers and the member's right to request continuation of services while utilizing the grievance system;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.7	Medical necessity definition as defined by DHH;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.8	Medical necessity review protocols and procedures;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.9	Practice protocols, including guidelines pertaining to the treatment of chronic and complex conditions;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.10	PCP responsibilities;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.11	Other provider or contract responsibilities;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.12	Prior authorization and referral procedures;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.13	Medical records standards;	Full	Addressed in Physician, Health Care Professional,	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	Contract Requirement Language	Review Determination	Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)	MCO Response and Plan of Action
			Facility and Ancillary Handbook.	
9.4.1.14	Claims submission protocols and standards, including instructions and information necessary for a clean and complete claim and samples of clean and complete claims;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.15	CCN prompt pre-processing requirements;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.16	CCN's Chronic Care Management Program;	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.17	Quality performance requirements; and	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.1.18	Member rights and responsibilities.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.4.2	The CCN shall disseminate bulletins as needed to incorporate any changes to the Provider Handbook.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook. Onsite Interview Plan Response: Changes are reflected in the multiple versions of the manuals that were submitted to IPRO. Also, changes are posted to the website.	
9.4.3	Prior to the implementation of the CCN program, the CCN may opt to provide generic provider handbook information. However, the CCN shall make available to network providers a Provider Handbook specific to the CCN Program, no later than thirty (30) days after the date the CCN signs the Contract with DHH.	Full	Addressed in Provider Network Development and Management Plan 11.16.11.	
9.4.4	The CCN may opt not to provide a hard copy of the provider handbook to out-of-network providers,	Full	Onsite Interview Plan Response: The provider directory is available on the plan's website.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	however if the CCN does not provide a hard copy the CCN must provide the website address the provider can obtain the CCN's provider handbook and related policies and procedures.			
9.6	**CCN Provider Complaint System**			
9.6.1	The CCN shall establish a Provider Complaint System for in network and out-of-network providers to dispute the CCN's policies, procedures, or any aspect of the CCNs administrative functions. As part of the Provider Complaint system, the CCN shall:	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; and in the Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.6.1.1	Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider complaint and resolve problems;	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; Physician, Health Care Professional, Facility and Ancillary Handbook; and LA CS Org Chart 08 2013(r).	
9.6.1.2	Identify a staff person specifically designated to receive and process provider complaints;	Full	Addressed in UHL_6-Provider Complaint System_v1 093011.	
9.6.1.3	Thoroughly investigate each provider complaint using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the CCN's written policies and procedures; and	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; and review of submitted provider complaint cases.	
9.6.1.4	Ensure that CCN executives with the authority to require corrective action are involved in the provider complaint process as necessary.	Full	Addressed in UHL_6-Provider Complaint System_v1 093011.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
9.6.2	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 by the CCN. The policies and procedures shall include, at a minimum:	Full	Addressed in UHL_6-Provider Complaint System_v1 093011.	
9.6.2.1	Allowing providers thirty (30) days to file a written complaint and a description of how providers file a complaint with the CCN and the resolution time;	Full	Addressed in UHL_6-Provider Complaint System_v1 093011.	
9.6.2.2	A description of how and under what circumstances providers are advised that they may file a complaint with the CCN for issues that are CCN Provider Complaints and under what circumstances a provider may file a complaint directly to DHH/MMIS for those decisions that are not a unique function of the CCN.	Substantial	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook; however language regarding filing complaints directly to DHH/MMIS is not present. Onsite Interview Response: DHH prefers that complaints are filed through the plan. Recommendation: Although the plan states that DHH prefers complaints are filed through the plan, the plan should still inform its providers of circumstances in which complaints can be filed directly with DHH.	MCO response: UHC will identify those circumstances which allow a Provider to file complaints directly to DHH, and revise the Handbook. IPRO response: Determination is unchanged. Updated handbook will be reviewed as part of next year's audit.
9.6.2.3	A description of how provider relations staff are trained to distinguish between a provider complaint and an enrollee grievance or appeal in which the provider is acting on the enrollee's behalf.	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; and in the Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.6.2.4	A process to allow providers to consolidate complaints that involve	Full	Addressed in UHL_6-Provider Complaint System_v1 093011.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	the same or similar issues, regardless of the number of individual patients or issues included in the bundled complaint;			
9.6.2.5	A process for thoroughly investigating each complaint using applicable subcontractual provisions, and for collecting pertinent facts from all parties during the investigation.	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; Provider Complaint System and Procedures; and review of submitted provider complaint cases.	
9.6.2.6	A description of the methods used to ensure that CCN executive staff with the authority to require corrective action are involved in the complaint process, as necessary;	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; and Provider Complaint System and Procedures.	
9.6.2.7	A process for giving providers (or their representatives) the opportunity to present their cases in person;	Full	Addressed in Provider Complaint System and Procedures; and Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.6.2.8	Identification of specific individuals who have authority to administer the provider complaint process;	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; and Provider Complaint System and Procedures.	
9.6.2.9	A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and	Full	Addressed in UHL_6-Provider Complaint System_v1 093011; Provider Complaint System and Procedures; and review of submitted provider complaint cases.	
9.6.2.10	A provision requiring the CCN to report the status of all provider complaints and their resolution to DHH on a monthly basis in the format required by DHH.	Full	Addressed in Provider Complaint Summary Reports.	
9.6.3	The CCN shall include a description	Full	Addressed in Physician, Health Care Professional,	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.		Facility and Ancillary Handbook.	
9.6.4	The CCN shall distribute the CCN's policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice of the pre-processed claim. The CCN may distribute a summary of these policies and procedures to providers if the summary includes information about how the provider may access the full policies and procedures on the CCN's website. This summary shall also detail how the in-network provider can request a hard copy from the CCN at no charge to the provider.	Full	Addressed in Network Development and Management Plan Annual Report Final; and Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook. Although precise language regarding the distribution of policies and procedures to out-of-network providers within the remittance advice of the pre-process claim is not presented, the provider handbook containing policies and procedures is publicly available on the web.	
9.6.5	The CCN provider shall file all appeals for the denial, reduction or suspension of medically necessary services through the state fair hearing process.	Full	Addressed in Provider Complaint System and Procedures; and Physician, Health Care Professional, Facility and Ancillary Handbook.	
9.6.5.1	Within fifteen (15) business days of the mailing of the Notice of Adverse Action, the aggrieved provider may request an administrative hearing with the Division of Administrative Law (DAL) by filing a request for administrative hearing with the DAL. After a decision is rendered by the DAL, the aggrieved provider	Full	Addressed in Provider Complaint System and Procedures.	

Provider Services				
State Contract Requirements [Federal Regulation: 438.10, 438.100]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.			
9.7	**Materials and Information for Out-of-Network Providers**			
9.7.0	The CCN shall provide the CCN's Grievance System policies and procedures to out-of-network providers upon written or verbal request.	Full	Addressed in Physician, Health Care Professional, Facility and Ancillary Handbook. Onsite Interview Response: Grievances System policy and procedures are in the provider handbook, which is available online for the public.	
9.8	**Reporting Requirements**			
9.8.0	The CCN shall submit to DHH monthly Provider Complaint Reports as specified by DHH.	Full	Addressed in Provider Complaint Summary Reports.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.1	**Enrollment Counseling**			
10.1.10.2	Automatic Assignments by CCN	N/A		
10.1.10.2.1	The CCN is responsible for developing a PCP automatic assignment methodology in collaboration with DHH to assign an enrollee to a PCP when the enrollee: does not make a PCP selection after a voluntary selection of a CCN; or selects a PCP within the CCN that has reached their maximum physician/patient ratio; or selects a PCP within the CCN that has restrictions/limitations (e.g. pediatric only practice).	Full	Addressed in P/P Auto Assignment Methodology	
10.1.10.2.2	Assignment shall be made to a PCP with whom, based on fee for service claims history or prior linkage, the member has a historical provider relationship. If there is no historical PCP relationship, the member shall be autoassigned to a provider who is the assigned PCP for an immediate family member enrolled in the CCN plan. If other immediate family members do not have an assigned PCP, autoassignment shall be made to a provider with whom a family member has a historical provider relationship.	Full	Addressed in P/P Auto Assignment Methodology	
10.1.10.2.3	If there is no member or immediate family historical usage members shall be autoassigned to a PCP using an algorithm developed by the proposer, based on the age and sex	Full	Addressed in P/P Auto Assignment Methodology. Document signed within 30 days of signature of the Contract.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	of the member and geographic proximity. The CCN and PCP automatic assignment methodology must be submitted, within thirty (30) days after the Contract is signed by the CCN, for approval by DHH prior to implementation. This methodology must be shared with subcontractors and members prior to enrollment.			
10.1.10.2.4	The CCN shall be responsible for providing to the Enrollment Broker, information on the number of Medicaid member linkages and remaining capacity of each individual PCP of additional Medicaid member linkages on a quarterly basis.	Full	Addressed in P/P Reporting Requirements Document. Sample file layout of quarterly PCP Linkage Report provided for review Network Development and Mgmt Plan discusses provider patient capacity limitations.	
10.1.10.2.5	If the member does not select a PCP and is auto assigned to a PCP by the CCN, the CCN shall allow the member to change PCP, at least once, during the first ninety (90) days from assignment to the PCP without cause.	Full	Addressed in P/P Auto Assignment Methodology	
10.1.10.2.5.1	Effective the ninety-first (91st) day, the member may be locked into the assignment to the selected PCP for a period of up to twelve (12) months beginning from the original date the member was assigned to the CCN.	Full	Addressed in P/P Auto Assignment Methodology	
10.1.10.2.6	If a member requests to change his or her PCP with cause, at any time during the enrollment period, the CCN must grant the request.	Full	Addressed in P/P PCP Changes LA	

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

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	to the CCN member for notification of disenrollment.			
10.1.11.1	Member Initiated Request - A member or his/her representative must submit an oral or written request to the Enrollment Broker to disenroll from a CCN. The member may disenroll for the following reasons:	Full	Plan stated during interview that the member must send a request to disenroll to the DHH. All requests for disenrollment (member initiated or plan initiated) come to the plan via the DHH. Member Handbook refers the member to call BAYOU HEALTH at the DHH for information regarding disenrollment. P/P Disenrollment states "All Voluntary Disenrollment requests from the Member received by CCN-S will be forwarded to the DEPARTMENT/Enrollment Broker for completion"	
10.1.11.1.1	For cause, at any time. The following circumstances are cause for disenrollment: the member moves out of the CCN's designated service area; the CCN does not, because of moral or religious objections, cover the service the member seeks; the member requests to be assigned to the same CCN as family members; the member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the ember to unnecessary risk; if DHH imposes intermediate sanction provisions; the contract between the CCN and DHH is terminated; and other reasons including, but not limited to: poor quality of care; lack of	Full	Narrative Member Disenrollment states that "No matter what the reason, they are processed if received on an Eligibility file" Member Handbook states that a member may voluntarily disenroll for the following reasons: "moving out of state; poor quality of care; unable to get access to care or the providers you need for your health care needs." During interview, the plan stated that member initiated disenrollment goes through the DHH before going to the plan.	

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**
	access to CCN core benefits and services covered under the Contract; documented lack of access within the CCN to providers experienced in dealing with the member's healthcare needs; or any other reason deemed to be valid by DHH and/or its agent.			
10.1.11.1.2	Without cause for the following reasons: during the 90 day opt-out period following initial enrollment with the CCN for voluntary members; during the 90 days following the postmark date of the member's notification of enrollment with the CCN; once a year thereafter during the member's annual open enrollment period; upon automatic re-enrollment , if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or if DHH imposes intermediate sanction provisions.	Full	Narrative Member Disenrollment states that "No matter what the reason, they are processed if received on an Eligibility file" During interview, the plan stated that member initiated disenrollment goes through the DHH before going to the plan.	
10.1.11.1.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Full	P/P Disenrollment states "All Voluntary Disenrollment requests from the Member received by CCN-S will be forwarded to the DEPARTMENT/ Enrollment Broker for completion."	
10.1.11.1.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	Full	During interview, the plan stated that member initiated disenrollment goes through the DHH before going to the plan.	
10.1.11.2	CCN Initiated Request	N/A		
10.1.11.2.1	The CCN shall submit requests for	Full	Addressed in P/P Disenrollment	

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

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**
	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 maintained in an identifiable member record.			
10.1.11.2.4	All requests will be reviewed on a case-by case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the discussion.	Full	Addressed in P/P Disenrollment	
10.1.11.2.5	DHH approved disenrollment requests shall be assisted and completed by the Enrollment Broker and in a manner so designated by DHH.	Full	Disenrollment document states “DHH, the CCN, and the Enrollment Broker shall reconcile enrollment/disenrollment issues at the end of each month utilizing an agreed upon procedure.”	
10.1.11.2.6	When the CCN requests an involuntary disenrollment, it shall notify the member in writing that the CCN is requesting disenrollment, the reason for the request, and an explanation that the CCN is requesting that the member be disenrolled in the month following member notification, or earlier if necessary. Until the enrollee is disenrolled by the Enrollment Broker, the CCN shall be responsible for the provision of services to that member. The Enrollment Broker will	Full	Addressed in P/P Disenrollment	

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**
	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.			
10.1.11.2.7	Until the member is disenrolled by the Enrollment Broker, the CCN shall continue to be responsible for the provision of all core benefits and services to the member.	Full	Addressed in P/P Disenrollment	
10.1.11.2.8	The CCN shall not request disenrollment because of the following: a member's health diagnosis; adverse change in health status; utilization of medical services; diminished medical capacity; pre-existing medical condition; refusal of medical care or diagnostic testing; uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the CCN's ability to furnish services to either this particular member or other members; or the member attempts to exercise his/her rights under the CCN's grievance system, or attempts to exercise her/her right to change, for cause, the primary care provider that he/she has chosen or been assigned.	Full	Addressed in P/P Disenrollment. P/P Disenrollment states "The CCN shall not request disenrollment for reasons other than those stated in this RFP and the Contract." RFP states "The only situations in which we would request that a member be disenrolled would be either because we have sufficient documentation that the member's condition or illness would be better treated by another plan or we have documentation to establish fraud, forgery or evidence of unauthorized abuse of the services"	
10.1.11.3	DHH Initiated Disenrollment - DHH	N/A	DHH responsibility	

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**
	will notify the CCN of the member's disenrollment due to the following reasons:			
10.1.11.3.1	Loss of Medicaid eligibility or loss of CCN enrollment eligibility;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.2	Death of a member;	Full	"All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.3	Member's intentional submission of fraudulent information;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.4	Member is incarcerated;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	

Eligibility, Enrollment & Disenrollment				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.226]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
10.1.11.3.5	Member moves out-of-state;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.6	Member becomes Medicare eligible;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.7	Member is placed in a long term care facility (nursing facility or intermediate care facility for persons with developmental disabilities);	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.8	Member is enrolled in a Medicaid home and community-based services waiver (HDBS);	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.9	Member elects to receive hospice	Full	The plan's Narrative on Disenrollment states "No	

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**
	services;		matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.10	Member requests to be assigned to the same CCN as family members;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system"	
10.1.11.3.11	The member needs related services to be performed at the same time, not all related services are available within the CCN and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system."	
10.1.11.3.12	The Contract between the CCN and DHH is terminated;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system."	
10.1.11.3.13	The member loses Medicaid eligibility;	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system." Addressed in list of defined "disenrollment categories, which UnitedHealthcare Community Plan uses to process Disenrollments" located in plan RFP.	
10.1.11.3.14	The members eligibility changes to	Full	The plan's Narrative on Disenrollment states "No	

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**
	an excluded eligibility group;		matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan system."	
10.1.11.3.15	To implement the decision of a hearing officer in an appeal proceeding by the member against the CCN or as ordered by a court of law.	Full	The plan's Narrative on Disenrollment states "No matter what the reason, they are processed if received on an Eligibility file. All Disenrollments received from DHH via Maximus are processed into the United HealthCare Community Plan 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**
11.12	**Member Education-Required Materials and Services**			
11.12.0	The CCN shall ensure all materials and services do not discriminate against Medicaid CCN members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the CCN.	Full	Addressed in UHL Member Education Required Materials – "Member Education – Required Materials and Services"	
11.12.1	New Member Orientation	N/A		
11.12.1.1	The CCN shall have written policies and procedures for the following, but not limited to: orienting new members of its benefits and services; role of the PCP; what to do during the transition period, (e.g. how to access services, continue medications, and obtain emergency or urgent medical services when transferring from FFS or CommunityCARE 2.0 to CCN, or from one CCN to another, etc); how to utilize services; what to do in an emergency or urgent medical situation; and how to a file a grievance and appeal.	Full	Addressed in P/P UHL Member Education Required Materials	
11.12.1.2	The CCN shall identify and educate members who access the system inappropriately and provide continuing education as needed.	Full	Addressed in P/P UHL Member Education Required Materials	
11.12.1.3	The CCN may propose, for approval by DHH, alternative methods for orienting new members and must be prepared to demonstrate their	Full	Addressed in P/P UHL Member Education Required Materials	

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

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

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	mailing); a Member Handbook;, and a Provider Directory (also must be available in searchable format on-line).			
11.13.2	Welcome Calls	N/A		
11.13.2.1	The CCN shall make welcome calls to new members within fourteen (14) business days of receipt of the enrollment file from DHH or the Enrollment Broker identifying the new enrollee. During the phase-in implementation of the CCN program, the CCN may have up to twenty-one (21) days to make welcome calls.	Full	Welcome Call SOP indicates that the HARC Department will attempt to contact all new members "within the first 30 days that they are on the health plan". The document indicates that the plan will adhere to state-specific requirements regarding welcome calls, "specifically including call timing (within 2 weeks of enrollment)". The Initial Member Contact Report includes rates for completed Welcome Calls within 14 days of enrollment.	
11.13.2.2	The CCN shall review PCP assignment if automatic assignment is made and assist the member in the process of changing their PCP as needed.	Full	Welcome Call SOP.doc and Welcome call talking points indicate the caller will assist member with PCP assignment.	
11.13.2.3	The CCN shall develop and submit to DHH for approval a script to be used during the welcome call to discuss the following information with the member: a brief explanation of the program; statement of confidentiality; the availability of oral interpretation and written translation services and how to obtain them free of charge; the concept of the patient-centered medical home, including the importance of the member(s) making a first appointment with his or her PCP for preventive care before the member requires care due to an illness or condition and	Full	Evidence found in LA Welcome Talking Points	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	instructions about changing PCPs; and a discussion to discover whether the member is pregnant has a chronic condition, or any special health care needs. Assistance in making an appointment with the PCP shall be offered to all members with such issues.			
11.13.2.4	The CCN shall make three (3) attempts to contact the member. If the CCN discovers that the member lost or never received the welcome packet, the CCN shall resend the packet.	Full	Policy regarding telephonic attempts found in P/P Welcome Call SOP Welcome Talking Points indicates that the caller will order the member a new welcome packet, if needed.	
11.13.2.5	The CCN shall report to DHH on a monthly basis the name, telephone number and Medicaid Recipient ID Number of each member it attempted to contact after three attempts and were unable to successfully make contact.	Substantial	P/P Welcome Call SOP states "These monthly reports indicate the number of new records that we received for the health plan, the number with valid phone numbers, the contact rate, and the number of members who responded to the questions". The individual member's telephone number is not included in the report.	MCO response: Report 097, New Member Contacts, is a format provided by DHH. There is no space requiring member's telephone number. UHC requests considering updating this rating to Full , or perhaps N/A. IPRO response: Review determination is unchanged. Format of Report 097 is noted and will be discussed with DHH. At this time, since the standard requires inclusion of the member's telephone number, this element should be added to the form or included in an accompanying document.
11.14	**CCN Member Handbook**			
11.14.1	The CCN shall develop and maintain a member handbook.	Full	Addressed in UHL Member Education Required Materials – "Member Handbook". Member Handbook provided for review. Dated 8/13.	
11.14.2	At a minimum, the member	N/A	See requirements below.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	handbook shall include the following information:			
11.14.2.1	Table of contents;	Full	Addressed in Member Handbook	
11.14.2.2	A general description about how CCNs operate, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the PCP selection process, and the PCP's role as coordinator of services;	Full	Addressed in Member Handbook	
11.14.2.3	Member's right to disenroll from CCN;	Full	Addressed in Member Handbook	
11.14.2.4	Member's right to change providers within the CCN;	Full	Addressed in Member Handbook	
11.14.2.5	Any restrictions on the member's freedom of choice among CCN providers;	Full	Addressed in Member Handbook	
11.14.2.6	Member's rights and protections;	Full	Addressed in Member Handbook	
11.14.2.7	The amount, duration, and scope of benefits available to the member under the Contract between the CCN and DHH in sufficient detail to ensure that members understand the benefits to which they are entitled and information about health education and promotion programs, including chronic care management;	Full	Addressed in Member Handbook	
11.14.2.8	Procedures for obtaining benefits, including prior authorization requirements;	Full	Addressed in Member Handbook	
11.14.2.9	Description on the purpose of the Medicaid card and the CCN card	Full	Addressed in 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**
	and why both are necessary and how to use them;			
11.14.2.10	The extent to which, and how, members may obtain benefits, including family planning services and specialized behavioral health services from out-of-network providers;	Full	Addressed in Member Handbook	
11.14.2.11	The extent to which, and how, after-hours and emergency coverage are provided, including:	Full	Addressed in Member Handbook	
11.14.2.11.1	What constitutes an emergency medical condition, emergency services, and post-stabilization services;	Full	Addressed in Member Handbook	
11.14.2.11.2	That prior authorization is not required for emergency services;	Full	Addressed in Member Handbook	
11.14.2.11.3	The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent;	Full	Addressed in Member Handbook	
11.14.2.11.4	The mechanism, incorporated in the member grievance procedures, by which a member may submit, whether oral or in writing, a service authorization request for the provision of services;	Full	Covered Benefits section addresses the member's ability to initiate a service request by calling the Preauthorization Line.	
11.14.2.11.5	The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by The CCN and	Full	Addressed in Member Handbook	
11.14.2.11.6	That the member has a right to use	Full	Addressed in 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**
	any hospital or other setting for emergency care;			
11.14.2.12	The post-stabilization care services rules;	Full	Addressed in Member Handbook	
11.14.2.13	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Full	Addressed in Member Handbook	
11.14.2.14	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the CCN's Contract with DHH, including pharmacy cost sharing for certain adults;	Full	Addressed in Member Handbook	
11.14.2.15	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the CCN if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Substantial	Addressed in Member Handbook. Does not specify that in situations where the member is a child, that the parent or guardian may object.	MCO response: UHC can add language that the parent or guardian of a child may object to medical care. IPRO response: Review determination is unchanged. Updated language to the Handbook will be reviewed as part of next year's audit.
11.14.2.16	For counseling or referral services that the CCN does not cover because of moral or religious objections, the CCN should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Full	P/P LA Narrative 11.14.2.16 states that UHC LA does "not deny coverage for any moral or religious reasons."	
11.14.2.17	Member grievance, appeal and state fair hearing procedures and time frames;	Full	Addressed in 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**
11.14.2.18	Grievance, appeal and fair hearing procedures that include the following:	N/A	See requirements below	
11.14.2.18.1	For State fair hearing:	Full	Addressed in Member Handbook	
11.14.2.18.1.1	The right to a hearing;	Full	Addressed in Member Handbook	
11.14.2.18.1.2	The method for obtaining a hearing; and	Full	Addressed in Member Handbook	
11.14.2.18.1.3	The rules that govern representation at the hearing.	Substantial (Determination changed to "Full")	Member Handbook only addresses the member's right to have someone represent them at the hearing. No mention of rules regarding the representation is included.	MCO response: Page 38 of the Member Handbook says:"You or a representative of your choice, or a provider, acting on your behalf with your written consent may file a State Fair Hearing request within 30 days from the date shown on our decision letter. You have the right to ask someone to represent you at the hearing." UHC requests considering updating this rating to Full. IPRO response: Determination is changed from "Substantial" to "Full" based on a re-review of the Member Handbook.
11.14.2.18.2	The right to file grievances and appeals;	Full	Addressed in Member Handbook	
11.14.2.18.3	The requirements and timeframes for filing a grievance or appeal;	Full	Addressed in Member Handbook	
11.14.2.18.4	The availability of assistance in the filing process;	Full	Addressed in Member Handbook	
11.14.2.18.5	The toll-free numbers that the member can use to file a grievance or an appeal by phone;	Full	Addressed in Member Handbook	
11.14.2.18.6	The fact that, when requested by the member:	N/A		
11.14.2.18.6.1	Benefits will continue if the member files an appeal or a request	Full	Addressed in 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**
	for state fair hearing within the timeframes specified for filing; and			
11.14.2.18.6.2	The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.	Non-Compliance	Language regarding payment of services if the final decision is adverse to the member is not found in the Member Handbook P/P Member Education Required Materials addresses this requirement. Recommendation: Include in the Member Handbook Grievance and Appeals section, language regarding any obligation of the member to pay the cost of services during or after the appeals process, in the event that the final decision is adverse to the member.	MCO response: UHC can add language to its Member Handbook informing the member of obligation to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. IPRO response: Determination is unchanged. Member Handbook will be reviewed as part of next year's audit.
11.14.2.18.7	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 services must be provided.	Full	Addressed in Member Handbook	
11.14.2.19	Information to call the Medicaid Customer Service Unit toll free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Full	Member Handbook states that the member has the responsibility to "Notify Member Services of a change in address, family status or other coverage information." P/P Member Call State Specific Learning Aid instructs member services personnel to complete a temporary update in system and direct members to contact the state for permanent update. Louisiana BAYOUHEALTH telephone number provided. Requirement found in P/P Member Education Required Materials	
11.14.2.20	How to make, change and cancel medical appointments and the	Full	Addressed in 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**
	importance of canceling and/or rescheduling rather than being a "no show";			
11.14.2.21	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Substantial	Addressed in Member Handbook. Member Handbook does not include a mailing address for Member Services.	MCO response: There are specific mailing addresses for specific member services at Grievance and Appeals (pg. 37) and Privacy Notices (pg. 41). UHC requests considering updating this rating to Full. IPRO response: Determination is unchanged. While a mailing address is included in the handbook for certain situations (e.g., fraud and abuse), a mailing address should be ideally included for general member inquiries and should be provided earlier in the Handbook, perhaps on page 2.
11.14.2.22	How to obtain emergency and non-emergency medical transportation;	Full	Addressed in Member Handbook	
11.14.2.23	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Full	Addressed in Member Handbook	
11.14.2.24	Information about the requirement that a member shall notify the CCN immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in a auto accident;	Full	Addressed in Member Handbook	
11.14.2.25	Reporting requirements for the member that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the CCN;	Full	Language in Member Handbook states that reporting this information to Member Services is "very important".	
11.14.2.26	Member responsibilities, appropriate and inappropriate	Substantial (Determination	Member Handbook includes member's responsibility to never give their ID card to anyone else. However, there	MCO response: In the Fraud and Abuse section (pg. 36) of the Member

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**
	behavior, and any other information deemed essential by the CCN or DHH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	changed to "Full"	is no mention that misuse of the card could result in loss of eligibility or legal action. P/P Disenrollment identifies ID card misuse as a reason for plan-initiated disenrollment. Under Member Handbook: Fraud and Abuse, the plan states that "anyone who intentionally makes a false statement…could lead to prosecution for fraud. It may also cause you to lose your LA UHC Community Plan benefits."	Handbook, it states that a member could lose their benefits or face legal action for misuse of the card. UHC requests considering updating this rating to Full. IPRO response: Based on a re-review of the Member Handbook, determination is changed to "Full".
11.14.2.27	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English, Spanish and Vietnamese;	Full	Addressed in Member Handbook	
11.14.2.28	Information on the member's right to a second opinion at no cost and how to obtain it;	Full	Addressed in Member Handbook	
11.14.2.29	Any additional text provided to the CCN by DHH or deemed essential by the CCN;	N/A		
11.14.2.30	The date of the last revision;	Full	Cover of Member Handbook has "8/13" printed on it.	
11.14.2.31	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	Addressed in Member Handbook	
11.15	**Member Identification (ID) Cards**			

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.15.1	CCN members will receive two (2) member identification cards.	Full	Addressed in Member Handbook. Member will receive Medicaid card as well as Member ID card	
11.15.1.1	A DHH issued ID card to all Medicaid eligibles, including CCN members. This card is not proof of eligibility, but can be used for accessing the state's electronic eligibility verification systems by CCN providers. These systems will contain the most current information available to DHH, including specific information regarding CCN enrollment. There will be no CCN specific information printed on the card. The CCN member will need to show this card to access Medicaid services not included in the CCN core benefits and services. A CCN issued member ID card that contains information specific to the CCN.	Full	Addressed in P/P LA-Member ID Cards PP v4.	
11.15.1.1.1	The members ID card shall at a minimum include, but not be limited to the following: the member's name and date of birth; the CCN's name and address; instructions for emergencies; the PCP's name and telephone numbers (including after-hours number, if different from business hours 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).	Substantial	P/P LA Member ID Cards v4 does not include requirement for after-hours telephone number.	MCO response: UHC can add language to its policy to specify member's ID card will have the PCP's after-hours telephone number if it is different from the business hours number. IPRO response: Review determination is unchanged. Updated policy will be reviewed as part of next year's audit.
11.15.2	The CCN may issue provide the CCN	Full	Addressed in P/P LA-Member ID Cards PP v4.	

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 ID card in a separate mailing from the welcome packet, however the card must be sent no later than ten (10) business days from the date of receipt of the file from DHH or the Enrollment Broker identifying the new enrollee. As part of the welcome packet information, the CCN must explain the purpose of the card, how to use the card, and how to use it in tandem with the DHH-issued card.			
11.15.3	The card may be issued without the PCP information if no PCP selection has been made on the date of the mailing.	Full	Addressed in P/P LA-Member ID Cards PP v4.	
11.15.4	Once PCP selection has been made by the member or through auto assignment, the CCN will reissue the card in keeping with the time guidelines of this RFP and the Contract. As part of the mailing of the reissued card, the CCN must explain the purpose of the reissued card, the changes between the new card and the previous card, and what the enrollee should do with the previous car.	Full	Addressed in P/P LA-Member ID Cards PP v4.	
11.15.5	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	Addressed in P/P LA-Member ID Cards PP v4.	
11.15.6	The holder of the member	Full	Addressed in P/P LA-Member ID Cards PP v4.	

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**
	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.			
11.15.7	The CCN shall ensure that its subcontractors can identify members in a manner which will not result in discrimination against the members, in order to provide or coordinate the provision of all core benefits and services and/or expanded services and out of network services.	Full	Addressed in P/P LA-Member ID Cards PP v4	
11.16	**Provider Directory for Members**			
11.16.1	The CCN shall develop and maintain a Provider Directory in four (4) formats:	N/A	See requirements below	
11.16.1.1	A hard copy directory for members and upon request, potential members;	Full	Addressed in P/P UHL Provider Directory Creation and Distribution	
11.16.1.2	Web-based, searchable, online directory for members and the public;	Full	Addressed in P/P UHL Online Provider Directory Creation and Distribution. The online directory is an electronic file of the hard copy directory that can be found on the plan's website. Document is searchable.	
11.16.1.3	Hard copy, abbreviated version for the Enrollment Broker; and	Full	The plan provided the provider directory "LAMA_dir_nb_Secure.6.20.12" which contains, in English and Spanish, listing of providers. The plan stated in interview that hard copy directories are mailed to the Enrollment Broker.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
11.16.1.4	Electronic file of the directory for the Enrollment Broker.	Full	UHL_11.16_Electroni Provider File_v2_111511 summarizes the process for maintaining such a directory.	
11.16.2	DHH or its designee shall provide the file layout for the electronic directory to the CCN after approval of the Contract. The CCN shall submit templates of its provider directory to DHH within thirty (30) days from the date the Contract is signed by the CCN.	Full	The plan submitted the document UHL_11.16_Electroni Provider File_v2_111511 for review. While the document references CCN-SHARED SAVINGS REQUEST FOR PROPOSALS, which includes this requirement, no UHC-specific document makes reference to this electronic file requirement. Rather than supply templates, the plan submitted to DHH and provided IPRO for review, a proof which served as the basis for all directory types. The proof is dated 11/3/2011.	
11.16.3	The hard copy directory for members shall be reprinted with updates at least annually. Inserts may be used to update the hard copy directories monthly for new members and to fulfill requests by potential members. The web-based online version shall be updated in real time, however no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be distributed to the new Medicaid enrollees. Format for this version will be in the format specified by DHH. The electronic version shall be updated prior to each submission to DHH's Fiscal intermediary and the Enrollment Broker. While daily updates are preferred, the CCN shall at a minimum submit no less than weekly.	Full	P/P Provider Directory Creation and Distribution states that the hard copy provider directory will be updated weekly. P/P Online Provider Directory Creation states that the online provider directory will be updated weekly. P/P Electronic Provider File states that the electronic provider record set will be updated at least weekly. P/P Member Education Required Materials addresses the inclusion of the hard copy provider directory in the member's Welcome Packet.	
11.16.4	The Provider Directory shall include, but not be limited to: names, locations, telephone numbers of,	Full	Hard copy Provider Directories provided for review. The plan does not contract with specialists. This is a state benefit. The Directory instructs the member to access	

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**
	and non-English languages spoken by current contracted providers in the Medicaid enrollee's service area, including identification of providers, PCPs, specialists, and hospitals at a minimum, that are not accepting new patients; identification of primary care physicians, specialists, and hospitals PCP groups, clinic settings, FQHCs and RHCs in the service area; identification of any restrictions on the enrollee's freedom of choice among network providers; and identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).		the plan's website, or call Member Services, to find a provider. Hard Copy Provider Directory does not indicate any restrictions to the member's choice of network providers. No indication of restrictions was present in the Member Handbook.	
11.16.5	To assist Medicaid potential enrollees in identifying participating providers for each CCN, the Enrollment Broker will maintain and update weekly an electronic provider directory that is accessible through the Internet and will make available, (by mail) paper provider directories which comply with the member education material requirements of this RFP.	N/A	Responsibility of the Enrollment Broker	
11.17	**Member Call Center**			
11.17.1	The CCN shall maintain a toll-free member service call center, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such	Full	Addressed in P/P LA Member Call PP V3 111811.	

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**
	topics as: explanation of CCN policies and procedures; prior authorizations; access information; information on PCPs or specialists; referrals to participating specialists; resolution of service and/or medical delivery problems; and member grievances.			
11.17.2	The toll-free number must be staffed between the hours of 7 a.m. and 7 p.m. Central Time, Monday through Friday, excluding State declared holidays. The toll-free line shall have an automated system available 24-hour a day, seven days a week. This automated system must include the capability of providing callers with operating instructions on what to do in case of an emergency, and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned. The CCN must ensure that the voice mailbox has adequate capacity to receive all messages and that member services staff return all calls by close of business the following business day.	Substantial (determination changed to "Full")	Addressed in P/P LA Member Call PP V3 111811. Recommendation: The plan should include in its policy, a requirement for a voice mailbox that has adequate capacity to receive all messages.	MCO response: UHC submitted another policy, Member Call PP V2, which does contain language about the recorded mail box, and our contingency plan should an emergency (including staffing, weather or systems) arise that re-directs calls to other call centers. In addition, UHC submitted its Case Management Plan. On page 10, it specifies routine after-hours calls are held in a voice mailbox. All messages are returned the next business day. UHC requests considering updating this rating to Full. IPRO response: Determination is changed to "Full" based on a review of the Call Center V2 Policy, which was in effect during the review period It is recommended that the policies be combined to avoid confusion between the two.
11.17.3	The CCN shall have sufficient telephone lines to answer incoming calls. The CCN shall ensure sufficient staffing to meet performance standards listed in this RFP. DHH reserves the right to specify staffing ratio and/or other requirements, if performance standards are not	Substantial	No policies or procedures provided regarding staffing in relation to the call center. Monthly Member Call Center shows that of the 13,772 incoming calls during the month of May 2013, 100% of calls were answered. Daily Percent of Calls Answered ranged from 98.17% to 100% for the month of May.	MCO response: Two policies address the need for adequate staffing in the call center: Member Call Center PP V2 and Member Call Center PP V3, including contingency for emergencies (weather, staffing, systems) and back up capabilities through other call centers. UHC requests considering updating this rating to Full.

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**
	meet or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by DHH.		Recommendation: The plan should include policy and procedure for ensuring adequate staffing and availability of phone lines.	IPRO response: Determination is unchanged. While Call Center policy discusses contingency planning, there isn't apparent policy that presents a formula for how the plan assesses the number of staff required to meet member needs or how understaffing is identified (e.g., computing a ratio of call center staff per member).
11.17.4	The CCN must develop a contingency plan for hiring call center staff to address overflow calls and emails and to maintain call center access standards set forth for CCN performance. The CCN must develop and implement a plan to sustain call center performance levels in situations where there is high call/e-mail volume or low staff availability. Such situations may include, but are not limited to, increases in call volume, emergency situations including natural disasters such as hurricanes), staff in training, staff illnesses and vacations.	Full	Addressed in P/P Member Call Center.	
11.17.5	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	Full	Addressed in P/P Member Call Center v2.	

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**
	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.			
11.17.6	The CCN shall develop call center quality criteria and protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the toll-free telephone line. The CCN shall submit call center quality criteria and protocols to DHH for review and approval annually.	Full	Addressed in P/P Member Call Center v2.	
11.17.7	Automatic Call Distribution - The CCN shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:	Full	Addressed in P/P Member Call Center v2.	
11.17.7.1	Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;	Full	Addressed in P/P Member Call Center v2. Interactive Voice Response directs caller to the appropriate staff.	
11.17.7.2	Transfer calls to other telephone lines;	Full	Addressed in P/P Member Call Center (IS 6).	
11.17.7.3	Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or	Full	Found in P/P Member Call Center (IS 6).	

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**
	referred; abandonment rate; wait time; busy rate; response time; and call volume;			
11.17.7.4	Provide a message that notifies callers that the call may be monitored for quality control purposes;	Full	Addressed in P/P Member Call PP v3.	
11.17.7.5	Measure the number of calls in the queue at peak times;	Full	Addressed in P/P Member Call PP v3.	
11.17.7.6	Measure the length of time callers are on hold;	Full	Addressed in P/P Member Call Center v2.	
11.17.7.7	Measure the total number of calls and average calls handled per day/week/month;	Full	Addressed in P/P Member Call Center v2.	
11.17.7.8	Measure the average hours of use per day;	Substantial	Monthly Member Call Center Report for May 2013 shows that the average length of call per day is recorded as is the total number of calls per day. Therefore, the average hours of use can be calculated; however, this calculation is not included in the report.	MCO response: Report 107 on Member Call Center statistics is on a template provided by DHH. There is no place to calculate average hours of use. UHC requests considering updating this rating to Full or N/A. IPRO response: Determination is unchanged. While the lack of a place for "average hours of use" on Report 107 is noted and will be discussed with DHH, the standard requires plans to report this element. The field can be entered manually or submitted as an adjunct to the form.
11.17.7.9	Assess the busiest times and days by number of calls;	Full	Addressed in P/P Member Call Center v2.	
11.17.7.10	Record calls to assess whether answered accurately;	Full	Addressed in P/P Member Call Center v2.	
11.17.7.11	Provide a backup telephone system that shall operate in the event of	Full	Addressed in P/P Member Call Center v2.	

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**
	line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;			
11.17.7.12	Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating IVR system; and	Full	Addressed in P/P Member Call Center v2.	
11.17.7.13	Inform the member to dial 911 if there is an emergency.	Full	Addressed in P/P Member Call Center v2.	
11.17.7.14	Performance Standards - Answer ninety-five (95) percent of calls within thirty (30) seconds or an automatic call pickup system; - No more than one percent (1%) of incoming calls receive a busy signal; Maintain an average hold time of three (3) minutes or less; Maintain abandoned rate of calls of not more than five (5) percent. The CCN must conduct ongoing quality assurance to ensure these standards are met. If DHH determines that it is necessary to conduct onsite monitoring of the CCN's member call center functions, the CCN is responsible for all reasonable costs incurred by DHH or its authorized Agent(s) relating to such monitoring.	Substantial	P/P Member Call Center v2 address the requirement that no more than 1 percent of incoming calls receive a busy signal, average hold time is 3 minutes or less and call abandonment rates are less 5%. The Member Call Center Report for May 2013 shows that the plan is meeting these standards, and has in place, a way of evaluating its performance. Policy regarding the plan's obligation to cover any costs related to DHH conducted on-site monitoring not found.	MCO response: UHC can create a policy obligating it to cover all reasonable costs of an onsite monitoring by DHH. IPRO response: Determination is unchanged. Updated policy will be reviewed as part of next year's audit.
11.18	**Member's Rights and Responsibilities**			
11.18.0	The CCN shall have written policies regarding member rights and responsibilities. The CCN shall comply with all applicable state and federal laws pertaining to member	Full	Addressed in P/P 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
	rights and privacy. The CCN shall further ensure that the CCN's employees, contractors and CCN providers consider and respect those rights when providing services to members.			
11.18.1	Members Rights - The rights afforded to current members are detailed in Appendix S, Members' Bill of Rights.	Full	Addressed in P/P Appendix S.	
11.18.2	Member Responsibilities	N/A	See requirements below.	
11.18.2.1	The CCN shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	Full	Addressed in P/P Member Handbook	
11.18.2.2	The CCN members' responsibilities shall include but are not limited to: informing the CCN of the loss or theft of their ID card; presenting their CCN ID card when using health care services; being familiar with the CCN procedures to the best of the member's abilities; calling or contacting the CCN to obtain	Full	Addressed in P/P 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**
	information and have questions answered; providing participating network providers with accurate and complete medical information; asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; living healthy lifestyles and avoiding behaviors known to be detrimental to their health; following the grievance process established by the CCN if they have a disagreement with a provider; and making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.			
11.19	**Notice to Members of Provider Termination**			
11.19.1	The CCN shall make a good faith effort to give advance written notice of a provider's termination to each member who received their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination	Full	Sample PCP Termination Letter to Members provided for review. Addressed in P/P Timeframes for Required Notification in Days.	

Member Education				
State Contract Requirements [Federal Regulation: 438.10, 438.100, 438.102, 438.218]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	notice from the provider.			
11.19.2	The CCN shall provide notice to a member, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within ten (10) calendar days from the date the CCN becomes aware of such, if it is prior to the change occurring.	Substantial	Sample PCP Closed Panel Letter to Members provided for review. No timeframes specified for member notification.	MCO response: UHC can add language to its policy to include timeframe for member notification. IPRO response: Determination is unchanged. Updated policy will be reviewed as part of next year's audit.
11.19.3	The requirement to provide notice prior to the dates of termination, shall be waived when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the GSA service area and fails to notify the CCN, or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately (same day) upon the CCN becoming aware of the circumstances.	Minimal	Sample letter given for review. Not specific to circumstances are noted where provider may become inactive. No timeframes specified for member notification.	MCO response: The contract language only serves to give examples of situations in which the requirement for timely notice may be waived, not the language of the notice. UHC can add language to its policy to include same day notification upon UHC becoming aware of the circumstances. UHC requests considering updating this rating to Substantial. IPRO response: Determination is unchanged. UHC should add the required language in the standard to its policy to be complaint. Updated policy will be reviewed as part of next year's audit.
11.20	**Additional Member Educational Materials and Programs**			
11.20.0	The CCN shall prepare and distribute educational materials, including, but not limited to, the following:	N/A	See requirements below.	
11.20.1	Bulletins or newsletters distributed not less than two (2) times a year that provide information on	Full	Addressed in P/P Member Education- Required Materials.	

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**
	preventive care, access to PCPs and other providers and other information that is helpful to members;			
11.20.2	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the CCN. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.3	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.4	Materials focused on health promotion programs available to the members;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.5	Communications detailing how members can take personal responsibility for their health and self management;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.6	Materials that promote the availability of health education classes for members;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.7	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.8	Materials that provide education to members, members' families and other health care providers about early intervention and management	Full	Addressed in P/P Member Education- Required Materials.	

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**
	strategies for various illnesses and/or exacerbations related to that disability or disabilities;			
11.20.9	Notification to its members of their right to request and obtain the welcome packet at least once a year;	Full	Addressed in P/P Member Education- Required Materials.	
11.20.10	Notification to its members of any change that DHH defines as significant at least thirty (30) calendar days before the intended effective date; and	Full	Addressed in P/P Member Education- Required Materials.	
11.20.11	All materials distributed must comply with the relevant guidelines established by DHH for these materials and/or programs.	Full	Addressed in P/P Member Education- Required Materials.	
11.21	**Oral and Material Interpretation Services**			
11.21.1	The CCN must make real-time oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish and Vietnamese). The enrollee is not to be charged for interpretation services. The CCN must notify its enrollees that oral interpretation is available for any language and written information is available in Spanish and Vietnamese and how to access those services. On materials where this information is provided, the notation should be written in both Spanish and Vietnamese.	Full	Addressed in 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**
11.21.2	The CCN shall ensure that where at least five percent (5%) or more of the resident population of a parish and/or service area is non-English speaking and speaks a specific foreign language, that materials are made available, at no charge, in that specific language to assure a reasonable chance for all members to understand how to access the CCN and use services appropriately.	Full	Addressed in P/P Member Education- Required Materials.	
11.22	**Marketing, Reporting, and Monitoring**			
11.22.1	Reporting to DHH	N/A		
11.22.1.1	The CCN must provide a monthly report in a format prescribed by DHH to demonstrate the progression of the marketing and member education plan. The monthly report must be provided by the 10th day of the following month and include a listing of all completed marketing activities and distributed marketing materials.	Full	Excel file UHC Marketing Activities Report contained listing of all events/materials distributed.	
11.22.1.2	A summary report of all marketing and member education efforts must be submitted to DHH within thirty (30) days of the end of the calendar year.	Full	Addressed 2012 UHC Marketing Activities Annual Review.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.0	**Member Grievances and Appeals**			
12.0.1	The CCN shall have a grievance system in place that includes a grievance process and access to a state fair hearing. The system shall comply with the requirements set forth in all federal and state laws and regulations. The CCN shall have written policies and procedures describing the grievance system. The CCN shall provide the policies and procedures to the Department for approval within thirty (30) days after the Contract is signed by the CCN and prior to implementation of any proposed revisions.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language and meets requirements. Also explained in member and provider handbooks.	
12.0.2	The CCN shall have a staff member designated as the grievance system coordinator and any additional staff necessary to comply with the requirements of this section, including those related to timeliness.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.0.3	The CCN shall dispose of the grievance and notify the member in writing of the resolution in a timely manner that is appropriate for the complexity of the grievance and the member's health condition. Most grievances should be resolved within ten (10) business days of receipt or sooner. All grievances shall be resolved within the time	Minimal (Determination changed to "Full")	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language regarding the need to notify members of the resolution. Review of 20 case files revealed that none contained a resolution letter in the file, though 11 were resolved in the same day. Moreover, five had no documentation of the resolution in the file. Five of 20 had no apparent investigation documented beyond talking to the	MCO response: UHC respectfully disagrees with this finding. •All 20 case files had resolution letters attached. •Five cases had combined acknowledgement / resolution letters due to insufficient information to investigate case. In these cases, all phone numbers on file were disconnected, invalid, or incorrect. We sent a letter out to reach out to the member to call Member

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	frames specified below. The CCN shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances in accordance with all applicable state and federal laws. All appeals received by the CCN must be logged and directly forwarded to the State Fair Hearing process.		member. Two cases, which involved member complaints of an incomplete evaluation/erroneous diagnosis, had no apparent involvement of health care staff in addressing the complaint.	Services again. After diligent efforts to contact the member, if we have no way to contact him or her to investigate the case, cases are closed. •Quality of Care cases cannot have the outcome of investigations on the resolution letter to member so that we may comply with federal peer review protection laws; this is stated in the resolution letter to the member: "Federal and/or state laws may not allow us to share our findings with you." •In cases where the member expresses dissatisfaction with provider or staff member behavior, we talk to the member and attempt to resolve their concern according to his/her wishes. All grievances are tracked and trended, but in accordance with our policy, an investigation of providers with complaints about rudeness, not listening, or other subjective behavioral concerns is not triggered unless 3 or more complaints within a 6 month period about the same provider for the same issue are received. So in these cases, it is appropriate that the extent of the investigation of the grievance would involve only talking with the member. •The auditor indicates that two cases had no apparent involvement of health care staff. UHC requested the case numbers of the two files in question, which were not received prior to this response being due. In lieu of that, the QI Director reviewed all 5 quality of care cases included in the case files provided to the auditor and all five cases had both nurse (RN) and physician (MD) review documented within the case notes that were provided to the auditor. UHC requests considering updating this rating to Full.

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
				IPRO response: Review determination changed to "Full." Based on a re-review of audit documentation, files were found to be complaint with this standard.
12.1	**Definitions**			
12.1.1	Action - A termination, suspension, or reduction (which includes denial of a service based on Federal Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.1.2	Appeal - A request for review of an action.	Full	UHL_12_Grievance System Process and Requirements_v1 093011 contains contract language.	
12.1.3	Grievance - An expression of dissatisfaction about any matter other than an action, as "action" is defined in this section. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights. The term is also used to refer to the overall system that includes CCN level grievances and access to State Fair Hearing.	Full	UHL_12_Grievance System Process and Requirements_v1 093011 contains contract language.	
12.2	**General Requirements**			
12.2.1	Grievance System - The CCN must have a system in place for members that include a grievance process,	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	and access to the State Fair Hearing system.		IPRO File Review 9/18/13 Findings: A grievance system is in place and actively utilized. Notification letters to providers and members address appeal process and access to State Fair Hearing, as do the member and provider handbooks. Complaints about PCPs addressed by advising to change providers. The plan is building on existing efforts to track and trend complaints about providers and follow-up with more substantive resolution as needed.	
12.2.2	Filing Requirements	N/A		
12.2.2.1	Authority to File	N/A		
12.2.2.1.1	A member or representative of their choice may file a grievance and may request a State Fair Hearing in response to an action	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.2.2.1.2	A network provider may file a grievance or request a State Fair Hearing on behalf of a member in response to an action.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.2.2.1.3	The CCN shall assure that no punitive action is taken against a provider who files a grievance on behalf of a member or supports a member's grievance.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.2.2.2	Timing - The member must be allowed thirty (30) calendar days from the date on the CCN's notice of action to request a State Fair Hearing. Within the timeframe the member, or a representative or provider acting on their behalf, may	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	request a State Fair Hearing.			
12.2.2.3	Procedures	N/A		
12.2.2.3.1	The member may file a grievance either orally or in writing with the CCN.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.2.2.3.2	The member, or a representative or provider acting on behalf of the member, may file for a State Fair hearing with the designated state entity either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed State Fair Hearing request.	Full	UHL_12_Grievance System Process and Requirements_v 093011 contains contract language.	
12.3	**Notice of Grievance and State Fair Hearing Procedures**			
12.3.1	The CCN shall ensure that all CCN members are informed of State Fair Hearing process and of the CCN's grievance procedures. The CCN shall provide to each member a member handbook that shall include descriptions of the CCN's grievance procedures. Forms on which members may file grievances, concerns or recommendations to the CCN shall be available through the CCN, and must be provided upon request of the member. The CCN shall make all forms easily available on the CCN's website.	Full	Telephone call and letter writing process explained. The Request for State Fair Hearing Form is provided in the member handbook. Once members log on to the website containing the member handbook, the member handbook with a grievance form included is accessible. IPRO File Review 9/18/13 Findings: Notification letters to providers and members address appeal process and access to State Fair Hearing, as do the member and provider handbooks.	
12.4	**Grievance Records and Reports**			
12.4.1	The CCN shall maintain a log of all	Full	Grievance and State Fair Hearing Log 2012 Q4	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	grievances and requests for fair hearings that shall be available to the Department in electronic format upon request.		addresses contract requirement.	
12.4.2	The CCN log shall be specific to the members covered by this RFP; entries in the log shall not be intermingled with entries about members from the CCN's other lines of business.	Full	Grievance and State Fair Hearing Log 2012 Q4 meets contract requirement.	
12.4.3	At a minimum, the log shall contain: the member's name and member ID number; the date of filing; a description of the issue; the date of resolution; a description of the resolution; whether the grievance was determined valid; and the date of member notification.	Substantial	UHC SS 117 Grievance and State Fair Hearing Log 2012 Q4 contains information that is required; however, member name was not included.	MCO response: UHC will add member name to Report 117. IPRO response: Determination is unchanged. Updated Report 117 will be reviewed as part of next year's audit.
12.4.4	A copy of the grievances log shall be retained for six (6) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the six (6) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular six (6) year period, whichever is later.	Full	UHL_12_Grievance system process and requirements_v1 093011 contains contract language.	
12.4.5	The CCN shall provide quarterly reports in electronic format to DHH by the fifth (5th) calendar day of the	Substantial	Contract language requires that the previous quarter report include information about trends identified and interventions that may have been implemented;	MCO response: Report 117 is a template provided by DHH. There is only a place for top 5 reasons for requests for a State

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	following end of the quarter, that include all grievances and, if reached, their resolutions. The reports covering the previous quarter (January-March, April-June, July-September and October-December), shall include information about any trends that have been identified and interventions that may have been implemented.		however, reviewer only able to locate the top 5 reasons for grievance (Jan-March report- UHC SS117 Q Grievance and State Fair Hearing Log 2013 Q1 redacted) but no interventions were noted.	Fair Hearing. There is no space to note interventions. UHC requests considering updating this rating to Full or N/A. IPRO response: Determination is unchanged. The absence of the required elements in Report 117 is noted and will be discussed with the DHH. However, at this time, the plan is required to report these elements and can do so by incorporating them into the current report or including them as an accompanying document.
12.4.6	These reports with PHI redacted will be made publicly available for inspection.	Full	Logs are reported to DHS.	
12.5	**Handling of Grievances**			
12.5.0	The grievance procedures shall be governed by the following requirements:	N/A		
12.5.1	General Requirements - In handling grievances, the CCN must meet the following requirements:	N/A		
12.5.1.1	The CCN shall give members reasonable assistance in completing grievance and other procedural steps, including, but not limited to, providing a toll-free telephone number, translation services, and a toll-free number with Telephone Typewriter (TTY)/Telecommunication Device for the Deaf (TDD) and interpreter capability.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language and member and provider handbooks meet contract requirement.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.5.1.2	Acknowledge receipt of each grievance.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.2	Resolution and Notification - Basic Rule: The CCN must dispose of a grievance and provide notice, as expeditiously as the member's health condition requires, within the timeframes established in 12.5.2.1 below.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.2.1	Specific Timeframes	N/A		
12.5.2.1.1	Standard Disposition of Grievances - For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the CCN receives the grievance. Extension of Timeframes. The CCN may extend the timeframes of this section by up to fourteen (14) calendar days if: the member requests the extension; or the CCN shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest. Requirements Following Extension - If the CCN extends the timeframes, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.3	Requirements for State Fair Hearings	N/A		
12.5.3.1	Availability - The member may	Full	UHL_12_Grievance System Process and	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	request a State Fair Hearing within thirty (30) days from the date of the notice of action following the resolution of the grievance.		Requirements_v1_093011 contains contract language.	
12.5.3.2	Parties - The parties to the State Fair Hearing include the CCN as well as the member and his or her representative or the representative of a deceased member's estate.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.3.3	Concurrent Appeal Review - The CCN shall conduct an internal concurrent review for each appeal for which a State Fair Hearing is requested. The purpose of the Concurrent Appeal Review is to expedite the resolution of the appeal to the satisfaction of the member, if possible, prior to the State Fair Hearing. The CCN shall notify the State Fair Hearing designated entity of Concurrent Appeal reviews resulting in a resolution in favor of the member. The Concurrent Appeal Review shall not delay the CCN's submission of an appeal to the State Fair Hearing process and shall not delay the review of the appeal in the State Fair Hearing.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.4	Special Requirements for State Fair Hearing - All State Fair Hearing by members or on their behalf shall be filed with the state designated entity; however, if the CCN receives	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	a State Fair Hearing request, the request shall be forwarded directly to the designated entity that will conduct the State Fair Hearing.			
12.5.4.1	The CCN's staff shall be educated concerning the importance of the State Fair Hearing procedures and the rights of the member and providers.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.5.4.2	The appropriate individual or body within the CCN that made the decision that is being brought to the State Fair Hearing shall be identified. This individual shall prepare the Summary of Evidence and be available for the State Fair Hearing either in person or by telephone.	Full	UHL_12_Grievance System Process and Requirements_v1_093011 contains contract language.	
12.6	**Notice of Action**			
12.6.0	Notice of Action will only be sent by the CCN in certain circumstances as specified in this RFP.	Substantial	Of 19 file reviews (20 total files reviewed but 1 file was to verify eligibility status), all but one included a notification letter.	MCO response: UHC will educate staff of the importance of notification letters. IPRO response: Determination is unchanged. Efforts to educate staff will be reviewed as part of next year's audit.
12.6.1	Language and Format Requirements - The notice must be in writing and must meet the language and format requirements of to ensure ease of understanding.	Full	All notification letters reviewed were written in an easy to understand format.	
12.6.2	Content of Notice - The notice must explain the following:	N/A	UCSMM 06.18 Initial Adverse Determination Notice	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.6.2.1	The action the CCN or its contractor has taken or intends to take;	Full	All notification letters reviewed explained the action the plan has taken or intends to take.	
12.6.2.2	The reasons for the action;	Full	All notification letters reviewed explained the reasons for the action.	
12.6.2.3	The member's right to request a State Fair Hearing and a number to call for free Legal Advice;	Full	All notification letters reviewed explained the right to request a State Fair Hearing.	
12.6.2.4	The procedures for exercising the rights specified in this section;	Full	All notification letters reviewed explained the procedures for exercising the procedures for exercising the rights specified in this section.	
12.6.2.5	The circumstances under which expedited resolution is available and how to request it; and	Full	All notification letters reviewed explained the expedited resolution process.	
12.6.2.6	The member's right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services.	Full	All notification letters reviewed explained the member’s right to continuation of benefits and circumstances under which the member might be required to repay the cost of these services.	
12.6.2.7	A statement in Spanish and Vietnamese that translation assistance is available at no cost and the toll free number to call to receive translation of the notice.	Full	UCSMM 06.18 Initial Adverse Determination Notice contains contract language and translations and telephone numbers provided in member handbook.	
12.6.3.8	Timing of Notice - The CCN must mail the notice within the following timeframes:	N/A		
12.6.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action.	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.6.3.2	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if the member, or the provider, requests extension; or the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	
12.6.3.3	If the CCN extends the timeframe it must: give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	
12.6.3.4	On the date the timeframe for service authorization expires.	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	
12.6.3.5	For expedited service authorization decisions where a provider indicates, or the CCN determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain,	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	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.			
12.6.3.6	The CCN may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or provider acting on behalf of the member requests an extension, or if the CCN justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	Full	UCSMM 06.16 Initial Review Timeframes contains contract language.	
12.6.3.7	DHH may conduct random reviews to ensure that members are receiving such notices in a timely manner.	N/A	UCSMM 06.16 Initial Review Timeframes contains contract language.	
12.7	**Continuation of Benefits While the State Fair Hearing Is Pending**			
12.7.1	If the enrollee requests a hearing before the date of action or within ten (10) days from the postmark of the notice, the agency may not terminate or reduce services until a decision is rendered after the hearing unless:	Full	UHL_12_Grievance system process and requirements_v1_093011 contains contract language.	
12.7.1.1	It is determined that the sole issue is one of Federal/state law or policy; and	Full	UHL_12_Grievance system process and requirements_v1_093011 contains contract language.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
12.7.1.2	The agency promptly informs the recipient in writing that services are to be terminated/reduced pending the hearing decision.	Full	UHL_12_Grievance system process and requirements_v1_093011 contains contract language.	
12.7.2	Member Responsibility for Services Furnished While the State Fair Hearing is Pending - If the final resolution of the appeal is adverse to the member, that is, upholds the CCN's action, the State may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.	Full	UHL_12_Grievance system process and requirements_v1_093011 contains contract language. IPRO File Review 9/18/13 Findings: Notification letters contain standard language that addresses above requirements.	
12.8	**Information about the Grievance System to Providers and Contractors**			
12.8.0	The CCN must provide the information about the grievance system to all providers and contractors at the time they enter into a contract as specified in this RFP.	Full	Contract language in UHL_12.0 Grievance system process and requirements_v1_093011; UHL_06and09_Provider Handbook_v5_10_11; and Grievance and the State Fair Hearing process in LA-M474545-LA-manual-CCNS_FINAL.4.13.	
12.9	**Recordkeeping and Reporting Requirements**			
12.9.0	Reports of grievances and resolutions shall be submitted to DHH. The CCN shall not modify the grievance procedure without the prior written approval of DHH.	Full	Contract language addressed in UHL_12.0 Grievance system process and requirements_v1_093011.	
12.10	**Effectuation of Reversed Decision Resolutions**			
12.10.0	If the CCN or the State Fair Hearing officer reverses a decision to deny,	Full	Contract language addressed in UHL_12_Grievance system process and requirements_v1_0930a, Section K.	

Member Grievances & Appeals				
State Contract Requirements [Federal Regulations: 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	limit, or delay services that were not furnished while the State Fair Hearing was pending, the CCN must authorize the disputed services promptly, and as expeditiously as the member's health condition requires.			

Reporting Requirements				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
16	**Reporting Requirements**			
16.1	The CCN is responsible for complying with all the reporting requirements established by DHH.	N/A		
16.3	The CCN shall create reports or files (known as Deliverables) using the formats, including electronic formats, instructions, and timeframes as specified by DHH and at no cost to DHH. Any changes to the format must be approved by DHH prior to implementation. The CCN shall provide to DHH and any of its designee's copies of reports generated by the CCN concerning CCN members and any additional reports requested by DHH or its designee in regard to performance of the Contract.	Full	Addressed by Reports Deliverable List (reviewed onsite)	
16.4	DHH will provide the CCN with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reports shall be submitted in accordance with the schedule outlined in this RFP. In the event that there are no instances to report, the CCN shall submit a reporting stating so.	Full	Addressed by plan's use of the following forms: UHC SS117 Grievance and State Fair Hearing Log; 182 UHC 2013 05 Provider Complaint Summary Report; and 058 UHC 2013 Annual PCMH Recognition Report	
16.5	The CCN shall certify all submitted data, documents and reports. The data that must be certified include, but are not limited to, enrollment information, financial reports, claims pre-processed and other information as specified within this	Full	Addressed by signed attestations for SI181UHCM120515 and 181-UHC 2013 08 (reviewed on site)	

Reporting Requirements				
State Contract Requirements [Federal Regulation: 438.242]	**Contract Requirement Language**	**Review Determination**	**Comments (Note: For any element that deviates from the requirements, an explanation of the deviation must be documented in the Comments section)**	**MCO Response and Plan of Action**
	RFP. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CCN must submit the certification concurrently with the certified data and documents. DHH will identify specific data that requires certification.			
16.5.1	The data shall be certified by one of the following: (1) CCN's Chief Executive Officer (CEO); (2) CCN's Chief Financial Officer (CFO); or (3) An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO	Full	Addressed by signed attestations for SI181UHCM120515 and 181-UHC 2013 08 (reviewed on site). Attestations were signed by the COO.	