Healthy Blue of Louisiana

2020 Compliance Audit

Review Period: April 01, 2019 – March 31, 2020

Final Report Issued February 2021

Prepared on Behalf of
The State of Louisiana
Louisiana Department of Health

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Introduction and Audit Overview

Introduction

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. Further, 42 CFR 438.350 requires states to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. States must further ensure that the EQRO has sufficient information to carry out the EQR, that the information be obtained from EQR-related activities, and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the Louisiana Department of Health (LDH) has contracted with IPRO, an EQRO, to conduct annual compliance audits every three years. The 2020 annual compliance audit was a partial audit of the MCO's compliance with contractual requirements during the period of April 1, 2019, through March 31, 2020. Requirements that were not fully compliant in the full 2019 annual compliance audit were reviewed.

This report presents IPRO's findings of the 2020 annual compliance audit for Healthy Blue of Louisiana (Healthy Blue).

Audit Overview

The purpose of the audit was to assess Healthy Blue's compliance with federal and state regulations regarding: access to care; structure and operations; grievance policies; provider network relations and network adequacy; quality measurement; fraud, waste and abuse; and utilization management.

The partial audit included an evaluation of Healthy Blue's policies, procedures, files, and other materials corresponding to the following seven contractual domains:

1. Eligibility and Enrollment
2. Marketing and Member Education
3. Member Grievances and Appeals
4. Provider Network Requirements
5. Quality Management
6. Fraud, Waste and Abuse
7. Core Benefits and Services

The file review component assessed the MCO's implementation of policies and its operational compliance with regulations related to complaints and grievances, member appeals, informal reconsiderations, care management (physical and behavioral health), utilization management, and provider credentialing and recredentialing.

Specifically, file review consisted of the following two areas:

1. Appeals
2. Case Management (behavioral and physical health)

Sample sizes for each file review type are presented in **Table 1**.

Table 1: File Review Sample Sizes

File Type	Sample Size
Appeals	10
Case Management (physical health)	10
Case Management(behavioral health)	10

The period of review was April 1, 2019, through March 31, 2020. All documents and case files reviewed were active during this time period.

For this audit, determinations of "full compliance," "substantial compliance," "minimal compliance," "non-compliance," and "not applicable" were used for each element under review. The definition of each of the review determinations is presented in **Table 2**.

Table 2: Review Determination Definitions

Review Determination	Definition
Full	The MCO is compliant with the standard.
Substantial	The MCO is compliant with most of the requirements of the standard, but has minor deficiencies.
Minimal	The MCO is compliant with some of the requirements of the standard, but has significant deficiencies that require corrective action.
Non-compliance	The MCO is not in compliance with the standard.
Not applicable	The requirement was not applicable to the MCO.

The 2020 annual compliance audit consisted of three phases: 1) pre-onsite documentation review, 2) video interviews, and 3) post-onsite report preparation.

Pre-onsite Documentation Review

To ensure a complete and meaningful assessment of the MCO's policies and procedures, IPRO prepared seven review tools to reflect the areas for audit. These seven tools were submitted to the LDH for approval at the outset of the audit process on April 8, 2020. The tools included the review elements drawn from the state and federal regulations. Based upon the LDH's suggestions, some tools were revised and issued as final. These final tools were submitted to the MCO on July 1, 2020, in advance of the onsite audit.

Once LDH approved the methodology, IPRO sent Healthy Blue a packet that included the review tools, along with a request for documentation and a guide to help MCO staff understand the documentation that was required. The guide also included instructions for submitting the requested information using IPRO's secure File Transfer Protocol (FTP) site.

To facilitate the audit process, IPRO provided the MCO with examples of documents that the MCO could furnish to validate its compliance with the regulations. Instructions regarding the file review component of the audit were also provided, along with a request for the universe of cases for each file review area under review. From the universe of cases, IPRO selected a sample for each area, which was reviewed onsite.

Prior to the onsite visit, the MCO submitted written policies, procedures and other relevant documentation to support its adherence to state and federal requirements. The MCO was given a period of approximately four weeks to submit documentation to IPRO. To further assist MCO staff in understanding the requirements of the audit process, IPRO convened a conference call for all MCOs undergoing the audit, with LDH staff in attendance, approximately two weeks after the request packet was sent to the MCOs. During the conference call, IPRO detailed the steps in the audit process, the audit timeline, and answered any questions posed by MCO staff.

After the MCO submitted the required documentation, a team of seven IPRO auditors was convened to review the MCO's policies, procedures, and materials, and to assess the MCO's concordance with the state's contract requirements. This review was documented using audit tools IPRO developed to capture the review elements and record the findings. These review tools with IPRO's initial findings were used to guide the video interviews.

Video Interviews

The video interview component of the audit was composed of two video interview sessions. In the first session conducted on August 13, 2020, file reviews that were considered less than fully compliant based upon review were discussed. In the second session on August 31, 2020, review of elements in each of the seven review tools that were considered less than fully compliant based upon review.

Interviews were used to further explore the written documentation and to allow the MCO to provide additional documentation, if available. File review, as indicated, was conducted to assess the MCO's implementation of policy in accordance to state standards. MCO staff was given two days from the close of the onsite review to provide any further documentation.

Post-onsite Report Preparation

Following the video interviews, draft reports were prepared. These draft reports included an initial review determination for each element reviewed, and either evidence that the MCO is compliant with the standard or a rationale for why the MCO was not compliant and what evidence was lacking. For each element that was deemed not fully compliant, IPRO provided a recommendation for the MCO to consider in order for them to attain full compliance.

Each draft report underwent a second level of review by IPRO staff members who were not involved in the first level of review. Once completed, the draft reports were shared with LDH staff for review. Upon LDH approval, the draft reports were sent to the MCO with a request to provide responses for all elements that were determined to be less than fully compliant. The MCO was given two weeks to respond to the issues noted on the draft reports.

After receiving the MCO's response, IPRO re-reviewed each element for which the MCO provided a response. As necessary, review scores were updated based on the response of the MCO.

MCO Summary of Findings

Summary of Findings

Table 3 provides a summary of the audit results by audit domain. Detailed findings for each of the elements that were less than "fully compliant" follow within this section of the report.

Please note this is a partial review. This table excludes full items from the prior review. Total compliance for each tool (including full items from prior year) will be higher for domains scoring less than 100%. Additionally, some items were new requirements for this review which may have impacted overall percentages

Table 3: Audit Results by Audit Domain

Audit Domain	Total Elements	Full	Substantial	Minimal	Non-compliance	N/A	% Full[1]
Eligibility and Enrollment	2	2	0	0	0	0	100%
Marketing and Member Education	1	1	0	0	0	0	100%
Member Grievances and Appeals	7	7	0	0	0	0	100%
Provider Network Requirements	17	8	9	0	0	0	47%
Quality Management	3	3	0	0	0	0	100%
Fraud, Waste and Abuse	30	30	0	0	0	0	100%
Core Benefits and Services	9	9	0	0	0	0	100%
Total	**69**	**60**	**9**	**0**	**0**	**0**	**87%**

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

As presented in **Table 3**, 69 elements were reviewed for compliance. Of the 69 elements, 60 were determined to fully meet the regulations, while 9 substantially met the regulations, 0 minimally met the regulations, and 0 were determined to be non-compliant. Zero elements were "not applicable." The overall compliance score indicates that 87% of regulations not fully compliant in the prior review have been addressed by the MCO and are now fully compliant.

IPRO extracted from each of the seven detailed reports those elements for which the MCO was found to be less than fully compliant. This information was compiled into a summary report to facilitate corrective action. **Table 4** presents this summary report and includes details about each element reviewed, the final review determination, the MCO's initial response, and, when possible, suggestions to achieve full compliance.

It is the expectation of LDH that Healthy Blue submits a corrective action plan for new elements determined to be less than fully compliant.

Each of the seven review tools and review determinations for each of the elements follow **Table 4**.

Table 4: Deficient 2019 Audit Elements

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
7.3	**Geographic Access Requirements**					
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .1 Travel distance for members living in rural parishes shall not exceed 30 miles; and .2 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan. In review of the 220 HBL Report, distance requirements are met for all rural parishes, but not for all urban parishes for both adult and adolescent primary care providers. **Recommendation** The MCO should improve access to PCPs for their urban members. **MCO Response**: As of July 2019 Adult Urban access is 97.8% and Pediatric Urban access is 98.4%; The Network team is working currently working with 3 large urban PCP groups to be added to our Network. • 348 HBL 2019 Q2 cover 348 HBL 2019 Q2 (Full Report)	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. **Recommendation** The MCO should improve access to PCPs for their urban members.	Healthy Blue will request exceptions for the following Parishes: Plaquemines, East & West Feliciana, Union, and Grant. For other deficient parishes the Network team will continue contracting efforts, if needed more exceptions will be requested.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence,	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for	Substantial This requirement is referenced in the Provider Network Development Plan. The MCO provided 220 HBL Reports. The Q4 2018 report indicates that distance	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all	

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	exceptions	requirements are mostly met for rural parishes, but they are not met for all urban parishes. **MCO Response**: HBL currently has ALL acute care hospitals located in the state under contract. **Final Review Determination** No change in review determination. As per the language of the contract, it states that travel distance shall not exceed 10 miles for all urban members. There may be a lack of hospitals in certain areas, which can pose as a limitation to the MCO meeting this requirement.		urban parishes. The state is considering whether it is appropriate to modify its contract requirements.	
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists .1 Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and .2 Travel distance shall not exceed 90 miles for all members. .3 Specialists included under this requirement are listed the Provider Network Companion Guide.. LDH reserves the right to add additional specialty types as needed to meet the medical	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan in Access to Specialists. In review of the 220 HBL reports, all the MCO's specialties (except ob/gyn) meet the access standard for accessibility within 90 miles. All specialties (except ob/ gyn) meet the requirement that at least 75% of members have access to the specialty in a 60-mile distance, and all members have access to specialists within 90 miles.	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance requirements were not met for: • Allergy/immunology (exceeds 90 miles) • Dermatology (exceeds 90 miles) • Endocrinology and metabolism (exceeds 90 miles)	The Template during the look back period was locked and could not be adjusted to include the 90 mile data. The change in the 220 report was as of 2/2019. Amendment # 3 from LDH has now corrected the template to align with the contract language. If you would like, HB can have Geo Access maps created to show adequacy of 100% within 90 miles.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	needs of the member population. .4 Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.		As listed in the Provider Network Development Plan, access to ob/gyns should not exceed 30 miles in rural parishes and shall not exceed 15 miles in urban parishes. Not all urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to ob/gyns for their rural and urban members. **MCO Response**: Currently HBL as 96.4% Urban and 95.4% rural access for OBGYN; Many Parishes in Louisiana do not have Hospitals and/or Hospitals that offer OB Services. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)		• Hematology/oncology (exceeds 90 miles) **Recommendation** The MCO should improve access for allergy/immunology, dermatology, endocrinology and metabolism and hematology/oncology specialties.	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services .1 Travel distance shall not exceed 20 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development Plan. In review of the 220 HBL Geo Access Report, all key geographic urban and rural areas meet the standard for accessibility. Most, but not all, of the other urban and rural	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **Recommendation**	For Lab services, Healthy Blue will work with the provider community to include office with CLIA certifications. For Radiology services, Healthy Blue continue contracting efforts with free standing imaging facilities and/or request exceptions from

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			parishes meet this requirement. **Recommendation** The MCO should improve access to lab services for all rural and urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language. **MCO Response**: Overall, HBL has 98.9% urban and 99.9% rural lab access; Network will target these area to improve access; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)		The MCO should improve access to lab and radiology services for members in urban parishes.	LDH for area without these services.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .1 Travel distance shall not exceed 10 miles in urban parishes; and .2 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development. The Q4 2018 reports indicate that distance requirements are met for rural parishes, but not for all urban parishes. **Recommendation** The MCO should improve access to pharmacies for all	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **Recommendation** The MCO should improve access to pharmacies for	Healthy Blue will work with our Pharmacy vendor to ensure compliance. A logic correction was implemented and future report will show compliance.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language. **MCO Response**: Overall, HBL has 98.3% urban and 100% Rural access. Network will work with our PBM to improve access in needed areas; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)		members in urban parishes.	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .1 Travel distance shall not exceed 10 miles in urban areas; and .2 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development Plan. Most, but not all, urban and rural parishes meet the access standard for hemodialysis centers. **Recommendation** The MCO should improve access to pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the requirement language.	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **Recommendation** The MCO should improve access to hemodialysis centers for members in urban parishes.	HB will request exceptions from LDH for Hemodialysis centers within the deficient parishes. Hemodialysis network participation is challenged with 3 main barriers: Lack of Hemodialysis providers within the state of Louisiana. Healthy Blue has contracts with all the National Providers and all but a few independent providers. The national hemodialysis companies have in the past purchased independent providers and

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			MCO Response: Overall, HBL 90.1% urban and 98.4% rural; The state has a limited number of these facilities and will work to improve the network. The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)			closed the less profitable. The mile/minute requirements very narrow for such specialized services with such limited access.
7.6	**Provider Enrollment**					
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	P/P for Provider Network P/P for Provider Termination Sample notice to providers Sample notice to LDH	Substantial In the Provider Network Development Plan, on page 24, it states that the MCO will provide immediate notification to the provider and notify LDH of the termination after the written notification to the provider soon after, but no later than 7 calendar days. This is not in line with current requirement language. However, the provider termination process was discussed on-site with staff, who stated that termination notices are sent out immediately or as soon as a decision has been reached on a provider's status and LDH has been informed of providers that should be terminated for cause. A	Substantial	This requirement is addressed in the Timely Notification of Participating Provider Termination-LA Policy and Procedure on page 2. An edit has been made addressing this requirement but was made after the review period on 8/3/20. **Recommendation** Recommendation is unchanged from prior year. The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language.	The Network development plan has been updated and will be submitted to LDH for approval. The policy has been updated.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			sample provider termination letter was provided after the on-site. A sample email to LDH notifying them of all provider termination letters was also provided. Additionally, the standard Report 145 HBL lists the names of providers who are terminated for cause. **Recommendation** The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language. **MCO Response**: Timely Notification of Participating Provider Termination policy, # 4 Page 6 of 8 **Final Review Determination** No change in review determination. Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same			

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.			
7.7	**Mainstreaming**					
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.	Provider contracts Provider Handbook/Manual	Substantial This requirement is partially addressed in the Provider Manual on page 65. The meaning of the requirement is addressed on pages 14 and 15 that services should not be administered to members in any way different from the public or those providers should not show preference to other insured or private-pay patients. However, the provider contracts do tell providers that they must not discriminate members based on sex, race, creed, and other discriminating factors, such as a person's status as a program contract beneficiary. **Recommendation** The MCO should define mainstreaming appropriately within the Provider Manual as well as communicate	Substantial	This requirement is met by the Provider Handbook on page 70. However this version of the provider manual was drafted after the review period 6.18.20. **Recommendation** The MCO should include in the next provider manual the relevant statements found on page 70 of the 6.18.20 draft Provider Manual.	The Mainstreaming language was added to the previous version of the Provider Manual, as reflected in our prior submission of the draft manual to IPRO. The manual, with the language incorporated, is still with LDH for review. Upon their approval, this document will be posted to the web portal as well.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			mainstreaming requirements in their various provider contracts. **MCO Response**: Healthy Blue will define mainstreaming appropriately within the Provider Manual. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.			
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:	Provider contracts Provider Handbook/Manual Member Handbook	Substantial The requirement is partially addressed in the provider contracts in the Non-discrimination. section. **Recommendation** The MCO should indicate in their provider contract(s) and provider manual that they will take affirmative action to mainstream and ensure members are provided covered services without discrimination. MCO **Response**: Healthy Blue will indicate in the provider manual that we will take affirmative action to	Substantial	This requirement is met by the Provider Manual on page 70. However, this version of the Provider Manual was drafted after the review period 6.18.20. **Recommendation** The MCO should include in the next Provider Manual the relevant statements found on page 70 of the 6.18.20 draft Provider Manual.	The Mainstreaming language was added to the previous version of the Provider Manual, as reflected in our prior submission of the draft manual to IPRO. The manual, with the language incorporated, is still with LDH for review. Upon their approval, this document will be posted to the web portal as well.

Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
			mainstream and ensure members are provided covered services without discrimination. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.			

MCO Final Audit Tools

Seven detailed final audit tool reports that correspond to each domain that was audited were prepared. These reports include IPRO's review determination for each element that was audited.

Eligibility, Enrollment, and Disenrollment

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
11.11	**Disenrollment**					
11.11.1	Disenrollment is any action taken by LDH or its designee to remove a Medicaid MCO member from the MCO following the receipt and approval of a written request for disenrollment or a determination made by LDH or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.					
11.11.2	The Enrollment Broker shall be the single point of contact to the MCO member for notification of disenrollment.	P/P for Member Disenrollment	Full			
11.11.3	**Member Initiated Disenrollment**					
11.11.3.0	A member may request disenrollment from an MCO as follows:					
11.11.3.1	For cause, at any time. The following circumstances are cause for disenrollment: • The MCO does not, because of moral or religious objections, cover the service the member seeks; • The member needs related services to be performed at the same time, not all related services are available within the MCO and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; • The contract between the MCO and LDH is terminated;	P/P for Member Disenrollment	Substantial This requirement is not fully communicated to members in the member handbook. Bullets 2, 4 and 7 were not specifically discussed in the handbook. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically bullets 2, 4 and 7, so members are clear on the reasons why they may disenroll from the MCO. MCO Response:	Full	This requirement is addressed in page 73 and 74 of the member handbook and BLA-Mem-1052-19 LA Op Member New Welcome Booklet EC.	

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Poor quality of care; • Lack of access to MCO core benefits and services covered under the contract; • Documented lack of access within the MCO to providers experienced in dealing with the member's healthcare needs; • The member's active specialized behavioral health provider ceases to contract with the MCO; • Member moves out of the MCO's service area, i.e. out of state; or • Any other reason deemed to be valid by LDH and/or its agent.		Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.			
11.11.3.2	Without cause for the following reasons: • During the ninety (90) day opt-out period following initial enrollment with the MCO for voluntary members; • During the ninety (90) days following the postmark date of the member's notification of enrollment with the MCO; • Once a year thereafter during the member's annual open enrollment period; • Upon automatic re-enrollment under 42 CFR §438.56(g), if a temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity; or • If LDH imposes the intermediate sanction provisions specified in 42 CFR §438.702(a)(3).	P/P for Member Disenrollment	Substantial This requirement is partially addressed on pages 1 and 60 of the member handbook. Bullet 1 and 3 were addressed in the handbook, but bullets 2 and 4 are missing. It also does not state that members can disenroll "without cause" due to the listed items. However, the contract language is addressed in the Disenrollment Policy. **Recommendation** The MCO should update the member handbook to include all the contract language, specifically make reference to bullets 2 and 4 and state these requirements do not require good cause. MCO Response: Per recommendation, member handbook in process of being updated. Target completion date - beginning of 4th qrtr. 2019. State approval required for all member handbook updates/changes.	Full	This requirement is addressed in pages 74 of the member handbook.	
11.11.3.3	The member (or his/ her representative)	P/P for Member	Full			

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Disenrollment				
11.11.3.4	If the member's request for disenrollment is denied by the Enrollment Broker, the member can appeal directly to the State Fair Hearing process.	P/P for Member Disenrollment	Full			
11.11.4	**MCO Initiated Disenrollment**					
11.11.4.1	The MCO shall not request disenrollment because of a member's health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from him or her special needs, unless it seriously impairs the MCO's ability to furnish services to either this particular member or other MCO members, the member attempts to exercise his/her rights under the MCO's grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)).	P/P for Member Disenrollment Member Notification Letter	Full			
11.11.4.2	The MCO shall not request disenrollment for reasons other than those stated in this RFP. (See Appendix U –**Guidelines for Involuntary Member Disenrollment**). In accordance with 42 CFR 438.56(b)(3), LDH will ensure that the MCO is not requesting disenrollment for other reasons by reviewing the mandatory MCO Disenrollment Request Forms submitted to the Enrollment Broker.	P/P for Member Disenrollment	Full			
11.11.4.3	The MCO may request involuntary disenrollment of a member if the member	P/P for Member Disenrollment	Full			

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	misuses or loans the member's MCO-issued ID card to another person to obtain services. In such case the MCO shall report the event to LDH;					
11.11.4.4	When the MCO request for involuntary disenrollment is approved by the Department, the MCO shall notify the member in writing of the requested disenrollment, the reason for the request, and the effective date.	P/P for Member Disenrollment Member Notification Letter	Full			
11.11.4.5	The MCO shall submit disenrollment requests to the Enrollment Broker which should include, at a minimum the member's name, ID number, detailed reasons for requesting the disenrollment, and a description of the measures taken to correct member behavior prior to requesting disenrollment, utilizing the **MCO Initiated Request for Member Disenrollment** form (See Appendix T).	P/P for Member Disenrollment	Full			
11.11.4.6	The MCO shall not submit a disenrollment request at such a date as would cause the disenrollment to be effective earlier than forty-five (45) calendar days after the occurrence of the event prompting the request for involuntary disenrollment. The MCO shall ensure that involuntary disenrollment documents are maintained in an identifiable member record.	P/P for Member Disenrollment	Full			
11.11.4.7	All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of LDH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.	P/P for Member Disenrollment	Full			
11.11.4.8	The Enrollment Broker will provide written					

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	notice of disenrollment to the member and request that the member choose a new MCO. The notice shall include a statement that if the member disagrees with the decision to disenroll the member from the MCO, the member has a right to file an appeal directly through the State Fair Hearing process.					
11.11.4.9	Until the member is disenrolled by the Enrollment Broker, the MCO shall continue to be responsible for the provision of all core benefits and services to the member.	P/P for Member Disenrollment	Full			

Marketing and Member Education

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
12.9	**Written Materials Guidelines**					
12.9.0	The MCO must comply with the following requirements as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.). The MCO shall also comply with guidance outlined in 42 CFR §438.10 and 42 USC §1396u-(2)(d)(2)(A)(i):					
12.9.1	All member materials must be in a style and reading level that will accommodate the reading skills of MCO Enrollees. In general the writing should be at no higher than a 6.9 grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy: • Flesch – Kincaid; • Fry Readability Index; • PROSE The Readability Analyst (software developed by Educational Activities, Inc.); • Gunning FOG Index; • McLaughlin SMOG Index; or • Other computer generated readability indices accepted by LDH.	P/P for Written Member Materials Guidelines Sample written member materials	Full			
12.9.2	All written materials must be clearly legible with a minimum font size of ten-point, preferably twelve-point, with the exception of Member ID cards, and or otherwise approved by LDH.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Full			
12.9.3	LDH reserves the right to require evidence that written materials for members have been tested against the 6.9 grade reading-level standard.					
12.9.4	If a person making a testimonial or	P/P for Written Member	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	endorsement for a MCO has a financial interest in the company, such fact must be disclosed in the marketing materials.	Materials Guidelines P/P for Disclosure of Financial Interest				
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	P/P for Written Member Materials Guidelines P/P for Compliance with "Person First" Policy Sample written member materials including Member Handbook	Full			
12.9.6	The quality of materials used for printed materials shall be, at a minimum, equal to the materials used for printed materials for the MCO's commercial plans if applicable.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Full			
12.9.7	The MCOs name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-paged marketing materials.	P/P for Written Member Materials Guidelines Sample written member materials	Full			
12.9.8	All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members of Interpretation Services	Full			
12.9.9	All written materials related to MCO and PCP enrollment shall advise potential enrollees to verify with the medical services providers they prefer or have an existing relationship with, that such medical services providers are participating providers of the selected MCO and are available to serve the enrollee.	P/P for Written Member Materials Guidelines Sample written member materials including Member Handbook	Full			
12.9.10	Alternative forms of communication must be provided upon request for persons with visual, hearing, speech, physical or developmental disabilities. These	P/P for Written Member Materials Guidelines P/P for Informing Members/Potential Members	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	alternatives must be provided at no expense to the member.	of Access to Alternative Forms of Communication				
12.9.15	Except as indicated, the MCO may develop their own materials that adhere to requirements set forth in this document or use state developed model member notices. State developed model notices must be used for denial notices and lock-in notices.					
12.11	**Member Education – Required Materials and Services**					
12.11	The MCO shall ensure all materials and services do not discriminate against Medicaid MCO members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment materials and processes from the MCO.	P/P for Member Education P/P for Member Disenrollment P/P for Member Enrollment P/P for Member Re-enrollment	Full			
12.11.3	**Member Materials and Programs for Current Enrollees**					
12.11.3.1	The MCO shall develop and distribute member educational materials, including, but not limited to, the following: A member-focused website which can be a designated section of the MCO's general informational website, and interactive media content such as a mobile device application, a mobile optimized website, or interactive social media;	Link to member portal	Full			
12.11.3.2	Bulletins or newsletters distributed not less than two (2) times a year that provide information on preventive care, access to PCPs and other providers and other information that is helpful to members;	Example of bullets/news letter	Full			
12.11.3.3	Literature, including brochures and posters, such as calendars and growth charts, regarding all health or wellness promotion programs offered by the MCO's Medicaid	Brochures and other examples of literature including EPSTD materials	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;					
12.11.3.4	Targeted brochures, posters and pamphlets to address issues associated with members with chronic diseases and/or special heath care needs;	Brochures and other examples targeted to members with chronic disease/SHCN	Full			
12.11.3.5	Materials focused on health promotion programs available to the members;	Member education materials	Full			
12.11.3.6	Communications detailing how members can take personal responsibility for their health and self-management;	Member handbook Member communications	Full			
12.11.3.7	Materials that promote the availability of health education classes for members;	Member handbook Member communications	Full			
12.11.3.8	Materials that provide education for members, with, or at risk for, a specific disability or illness;	Example Member education material	Full			
12.11.3.9	Materials that provide education to members, members' families and other health care providers about early intervention and management strategies for various illnesses and/or exacerbations related to that disability or disabilities;	Example Member education material	Full			
12.11.3.11	Notification to its members of any change that LDH defines as significant at least thirty (30) calendar days before the intended effective date; and	Notification P/P member education	Full			
12.11.3.12	All materials distributed must comply with the relevant guidelines established by LDH for these materials and/or programs.	P/P member education	Full			
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere to the requirements in 42 CFR §438.10 (g) and may use the state developed model	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member handbook for each of the covered populations as specified in section 3.3.3.).					
12.12.1.1	At a minimum, the member handbook shall include the following information, as applicable to the covered population that is the audience for the handbook:					
12.12.1.2	Table of contents;	Member Handbook				
12.12.1.3	A general description about how MCOs operate, and detailed descriptions of the following: enrollee rights and responsibilities, appropriate utilization of services including ED for non-emergent conditions, behavioral health services available, a description of the PCP selection process, the PCP's role as coordinator of services, and an explanation of how the enrollees can access LDH's policy on how to receive continued services during a termination of an MCO contract or disenrollment from an MCO as required by 42 CFR §438.62;	Member Handbook	Full			
12.12.1.4	Member's right to disenroll from MCO including disenrollment for cause;	Member Handbook	Full			
12.12.1.5	Member's right to select and change PCPs within the MCO and how to do so;	Member Handbook	Full			
12.12.1.6	Any restrictions on the member's freedom of choice among MCO providers;	Member Handbook	Full			
12.121.7	Member's rights and protections, as specified in 42 CFR §438.100 and this RFP;	Member Handbook	Full			
12.12.1.8	The amount, duration, and scope of benefits available to the member under the contract between the MCO and LDH in sufficient detail to ensure that members understand the benefits to which they are entitled, including specialized behavioral health benefits and information about health education and promotion programs,	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	including chronic care management, tobacco cessation, and problem gaming;					
12.12.1.9	Procedures for obtaining benefits, including authorization requirements;	Member Handbook	Full			
12.12.1.10	Description on the purpose of the Medicaid card and the MCO card and why both are necessary and how to use them;	Member Handbook	Full			
12.12.1.11	The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers. An explanation shall be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider;	Member Handbook	Full			
12.12.1.12	The extent to which, and how, after-hours, crisis and emergency coverage are provided, including: • What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a); • That prior authorization is not required for emergency services; • The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent; • The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered by the MCO; and • That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.	Member Handbook	Full			
12.12.1.13	The post-stabilization care services rules set	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	forth in 42 CFR 422.113(c);					
12.12.1.14	Policy on referrals for specialty care, including specialized behavioral health services and for other benefits not furnished by the member's PCP;	Member Handbook	Full			
12.12.1.15	How and where to access any benefits that are available under the Louisiana Medicaid State Plan but, are not covered under the MCO's contract with LDH;	Member Handbook	Full			
12.12.1.16	That the member has the right to refuse to undergo any medical service, diagnoses, or treatment or to accept any health service provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;	Member Handbook	Full			
12.12.1.17	For counseling or referral services that the MCO does not cover because of moral or religious objections, the MCO should direct the member to contact the Enrollment Broker for information on how or where to obtain the service;	Member Handbook	Full			
12.12.1.18	Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and this RFP;	Member Handbook	Full			
12.12.1.19	Grievance, appeal and fair hearing procedures that include the following: • For State Fair Hearing: o The right to a hearing; o The method for obtaining a hearing; and o The rules that govern representation at the hearing; • The right to file grievances and appeals; • The requirements and timeframes for filing a grievance or appeal;	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• The availability of assistance in the filing process; • The toll-free numbers that the member can use to file a grievance or an appeal by phone; • The fact that, when requested by the member: o Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and o The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. • In a State Fair Hearing, the Division of Administrative Law shall make the recommendation to the Secretary of the LDH who has final authority to determine whether services must be provided.					
12.12.1.20	Advance Directives, set forth in 42 CFR §438. 10 (g)(2) (xii) - A description of advance directives which shall include: • The MCO policies related to advance directives; • The member's rights under Louisiana state law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change; • Information that members can file complaints about the failure to comply	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	with an advance directive with the Office of Health Standards, Louisiana's Survey and Certification agency) by calling 225 342 0138; and • Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.					
12.12.0.21	Information to call the Medicaid Customer Service Unit toll free hotline, go to Louisiana Medicaid website at www.medicaid.la.gov ,or visit a regional Medicaid eligibility office to report if family size, living arrangements, parish of residence, or mailing address changes;	Member Handbook	Full			
12.12.1.22	How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";	Member Handbook	Full			
12.12.1.23	A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;	Member Handbook	Full			
12.12.1.24	How to obtain emergency and non-emergency medical transportation;	Member Handbook	Full			
12.12.1.25	Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	Member Handbook	Full			
12.12.1.26	Information about the requirement that a member shall notify the MCO immediately if he or she has a Workman's Compensation claim, a pending personal injury or medical malpractice law suit, or has been involved in an auto accident;	Member Handbook	Full			
12.12.1.27	Reporting requirements for the member that has or obtains another health insurance policy, including employer	Member Handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	sponsored insurance. Such situations shall be reported the MCO;					
12.12.1.28	Member responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the MCO or LDH. This shall include a statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the member's Medicaid eligibility and/or legal action;	Member Handbook	Full			
12.12.1.29	Instructions on how to request multi-lingual interpretation and translation when needed at no cost to the member. This instruction shall be included in all versions of the handbook in English and Spanish ;	Member Handbook	Full			
12.121.30	Information on the member's right to a second opinion in accordance with 42 CFR §438.206(b)(3) at no cost and how to obtain it;	Member Handbook	Full			
12.12.1.31	Ways to report suspected provider fraud and abuse including but not limited to LDH and MCO toll-free numbers and website established for that purpose;	Member Handbook	Full			
12.12.1.32	Any additional text provided to the MCO by LDH or deemed essential by the MCO;	Member Handbook	Full			
12.12.1.33	The date of the last revision;	Member Handbook	Full			
12.12.1.34	Additional information that is available upon request, including the following: Information on the structure and operation of the MCO; Physician incentive plans [42 CFR 438.3 (i)]. Service utilization policies; and How to report alleged marketing violations to LDH utilizing the Marketing Complaint Form.	Member Handbook	Full			
12.12.1.35	Information regarding specialized behavioral health services, including but	Member handbook	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	not limited to: • A description of covered behavioral health services; • Where and how to access behavioral health services and behavioral health providers; • General information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult engagement; resilience; strength-based and evidence-based practice; and best/proven practices; • Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and • Any limitations involving the provision of information for adult persons who do not want information shared with family members, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.					
12.12.1.36	Information on what to do if a member is billed, and under what circumstances a member may be billed for non-covered services;	Member handbook	Full			
12.12.1.37	The information specified in 12.12.1 et. seq. will be considered to be provided if the MCO:	Member handbook	Full			
12.12.1.37.1	Mails a printed copy of the information to the member's mailing address;		Full			
12.12.1.37.2	Provides the information by email after obtaining the member's agreement to receive the information by email;		Full			
12.12.1.37.3	Posts the information on their member		Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	website and advises the member in paper or electronic form that the information is available at the specified web address; or					
12.12.1.37.4	Provides the information in any other method that can be reasonably expected to result in the member receiving the information.		Full			
12.12.1.38	At least once a year, the MCO must notify the member of their option of receiving either the Member Handbook or the member Welcome Newsletter in either electronic format or hardcopy, upon request from the member.	Member notification	Full			
12.12.1.39	The MCO shall review and update the Member Handbook at least once a year. The Handbook must be submitted to LDH for approval within four weeks of the annual renewal, upon any changes, and prior to being made available to members.	Dated revision of member handbook	Full			
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	P/P for Provider Directory Provider Directory	Full			
12.14.1.1	A hard copy directory, when requested, for members and potential members;	P/P for Provider Directory Provider Directory (hard copy)	Full			
12.14.1.2	Web-based searchable, web-based machine readable, online directory for members and the public;	P/P for Provider Directory Provider Directory (website link)	Full This requirement is addressed through the web URL that was submitted for the provider directory. **<u>Final Review Determination</u>** This requirement was changed to Full based on the MCO response. Upon reviewing the initial provider directory screenshot there was a link to a machine readable web page.			
12.14.1.3	Electronic file of the directory to be	P/P for Provider Directory	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	Provider Directory (electronic file format)				
12.14.1.4	Hard copy, abbreviated version upon request by the Enrollment Broker.	P/P for Provider Directory Provider Directory (abbreviated hard copy)	Full			
12.14.3	The hard copy directory for members shall be reprinted with updates at monthly or no more than 30 days after the receipt of updated provider information. Inserts may be used to update the hard copy directories monthly to fulfill requests by members and potential members. The web-based online version shall be updated in real time, but no less than weekly. While daily updates are preferred, the MCO shall at a minimum submit no less than weekly. The abbreviated hard copy version for the Enrollment Broker will be available to all Medicaid enrollees when requested by contacting the Enrollment Broker. Format for this version will be in a format specified by LDH.	P/P for Provider Directory	Full			
12.14.4	In accordance with 42 CFR 438.10(f) (6), the provider directory shall include, but not be limited to:					
12.14.4.1	Names, locations, telephone numbers of, website URLs, specialties, whether the provider is accepting new members, and cultural and linguistic capabilities by current contracted providers by each provider type specified in this RFP in the Medicaid enrollee's service area. Cultural and linguistic capabilities shall include languages offered by the provider or a skilled medical interpreter at the provider's	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial This requirement is partially addressed in the Provider Directories Policy and submission of the hard copy directory as well as the web link. However, website URLs and the providers cultural competency training are not included. **Recommendation**	Full	This requirement is addressed in the screenshot and provider directory that Healthy Blue provided.	

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment;		Healthy Blue should include both the website URL and the provider's cultural competency training in their directory. **Final Review Determination** No change in findings. While the website does contain the provider URL and cultural competency information when available, this requirement is for the hard copy directory which does not contain this information. MCO Response: Healthy Blue includes the website URL (if the provider has one), as well as cultural competency training in the provider directory. (See evidence "Provider Directory Website_2").			
12.14.4.2	Identification of qualified providers divided into specific provider and service types and specializations, including but not limited to, primary care physicians, specialists, hospital PCP groups, clinic settings, home and community-based services, outpatient therapy, residential substance use, youth residential services, inpatient mental health and residential substance use services, and FQHCs and RHCs in the service area. This shall include a child serving list that is both monitored and frequently updated to ensure viable options are identified and available for OJJ, DCFS and LDOE field staff. The MCO provider types shall be delineated by parish and zip code;	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Full			
12.14.4.3	Identification of any restrictions on the enrollee's freedom of choice among network providers; and	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		file, abbreviated hard copy)				
12.14.4.4	Identification of hours of operation including identification of providers with non-traditional hours (Before 8 a.m. or after 5 p.m. or any weekend hours).	P/P for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Full			
12.17.15	**Members' Rights and Responsibilities**					
12.17.15.1	The MCO shall have written policies regarding member rights and responsibilities. The MCO shall comply with all applicable state and federal laws pertaining to member rights and privacy. The MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.17.16	**Member Responsibilities**					
12.17.16.1	The MCO shall encourage each member to be responsible for his own health care by becoming an informed and active participant in their care. Members have the responsibility to cooperate fully with providers in following mutually acceptable courses of treatment, providing accurate medical and personal histories, and being present at scheduled appointments and reporting on treatment progress, such as notifying their health care provider promptly if serious side effects and complications occur, and/or worsening of the condition arises.	P/P for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.17.16.2	The MCO members' responsibilities shall	P/P for Member Rights and	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	include but are not limited to: • Informing the MCO of the loss or theft of their ID card; • Presenting their MCO ID card when using health care services; • Being familiar with the MCO procedures to the best of the member's abilities; • Calling or contacting the MCO to obtain information and have questions answered; • Providing participating network providers with accurate and complete medical information; • Asking questions of providers to determine the potential risks, benefits and costs of treatment alternatives and following the prescribed treatment of care recommended by the provider or letting the provider know the reasons the treatment cannot be followed, as soon as possible; • Living healthy lifestyles and avoiding behaviors know to be detrimental to their health; • Following the grievance process established by the MCO if they have a disagreement with a provider; and • Making every effort to keep any agreed upon appointments, and follow-up appointments; and accessing preventive care services, and contacting the provider in advance if unable to keep the appointment.	Responsibilities Member Handbook				
12.18	**Notice to Members of Provider Termination**					
12.18.1	The MCO shall make a good faith effort to give written notice of a provider's termination to each member who received	P/P for Provider Termination P/P for notifying members of provider termination	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	their primary care from, or was seen on a regular basis by the terminated provider. When timely notice from the provider is received, the notice to the member shall be provided within fifteen (15) calendar days of the receipt of the termination notice from the provider.					
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable. The written notice shall be provided within seven (7) calendar days from the date the MCO becomes aware of such, if it is prior to the change occurring. Failure to provide notice prior to the dates of termination will be allowed when a provider becomes unable to care for members due to illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster. Under these circumstances, notice shall be issued immediately upon the MCO becoming aware of the circumstances.	P/P for Provider Termination P/P for notifying members of provider termination	Full			
12.19	**Oral Interpretation and Written Translation Services**					
12.19.1	In accordance with 42 CFR §438.10(d) LDH shall provide on its website the prevalent non-English language spoken by enrollees in the state.					
12.19.2	The MCO must make real-time oral interpretation services available free of	P/P for oral and written interpretation services	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that Louisiana specifically requires (Spanish). The enrollee is not to be charged for interpretation services. The MCO must notify its enrollees that oral interpretation is available for any language and how to access those services. On materials where this information is provided, the notation should be written in Spanish.	P/P for notification of member of interpretation services and how to access the services				
12.19.3	The MCO shall ensure that translation services are provided for all written marketing and member education materials for any language that is spoken as a primary language for four percent (4%) or more enrollee or potential enrollees of an MCO. Within ninety (90) calendar days of notice from LDH, materials must be translated and made available. Materials must be made available at no charge in that specific language to assure a reasonable chance for all members to understand how to access the MCO and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).	P/P for oral and written interpretation services P/P for notification of member of interpretation services and how to access the services	Full			
12.19.4	Written materials must also be made available in alternative formats upon request of the potential member or member at no cost. Auxiliary aids and services must also be made available upon request of the potential member or member at no cost. Written materials must include taglines in the prevalent non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to	P/P for Member Rights and Responsibilities	Full			

Marketing and Member Education						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.10, 438.100)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's member/customer service unit. Large print means printed in a font size no smaller than 18 point.					

Member Grievances and Appeals

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.0	**Member Grievance and Appeals Procedures**					
13.2	**General Grievance System Requirements**					
13.2.1	Grievance System. The MCO must have a system in place for members that include a grievance process, an appeal process, and access to the State Fair Hearing system, once the MCO's appeal process has been exhausted. The MCO shall permit a member to file a grievance and request an MCO level appeal subject only to the limitations expressly provided in this Section. A member shall be permitted to request a State Fair Hearing after receiving notice that the action is upheld or once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing	Full			
13.2.2	**Filing Requirements**					
13.2.2.1	**Authority to File**					
13.2.2.1.1	A member, or authorized representative acting on the member's behalf, may file a grievance and an MCO level appeal, and may request a State Fair Hearing, once the MCO's appeals process has been exhausted.	P/P for Grievances P/P for Appeals P/P for Fair Hearing	Full			
13.2.2.1.2	A network provider, acting on behalf of the member and with the member's written consent, may file an appeal. A network provider may file a grievance or request a State Fair Hearing on behalf of a member.	P/P for Grievances P/P for Appeals P/P for Fair Hearing	Full			
13.2.3	**Time Limits for Filing** The member shall be permitted to file a grievance at any time. The member must be allowed sixty (60)	P/P for Grievances P/P for Appeals P/P for Fair Hearing	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	calendar days from the date on the MCO's notice of action or inaction to request an appeal.					
13.2.4 13.2.4.1	**Procedures for Filing** The member may file a grievance orally or in writing with either LDH or the MCO.	P/P for Grievances	Full			
13.2.4.2	The member or provider may file an appeal either orally or in writing. The oral appeal shall be followed by a written, signed appeal unless the member requests an expedited resolution.	P/P for Appeals P/P for Fair Hearing	Substantial This requirement is partially addressed in the Member Appeals – Core Process LA Policy. **<u>Recommendation</u>** The MCO should finalize updated policy to include new language. <u>MCO Response:</u> Member Appeals – Core Process Policy page 2 of 16 **<u>Final Review Determination</u>** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Full	This requirement is addressed within the Member Appeals – Core Process – LA policy on page 2.	
13.2.4.3	The MCO shall ensure that all MCO members are informed of the State Fair Hearing process and of the MCO's grievance and appeal procedures. The MCO shall provide to each member a member handbook that shall include descriptions of the MCO's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the MCO shall be available through the MCO, and paper copies must be provided by the MCO upon	P/P for Grievances P/P for Appeals P/P for Fair Hearing	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	request of the member. The MCO shall make all forms easily available on the MCO's website.					
13.3	**Grievance/Appeal Records and Report**					
13.3.1	The MCO must maintain accurate records of all grievances and appeals in a manner accessible to LDH and available upon request to CMS. A copy of grievances logs and records of disposition of appeals shall be retained for ten (10) years. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of issues which arise from it or until the end of the regular ten (10) year period, whichever is later.	P/P for Grievances P/P for Appeals	Full			
13.3.2	The MCO shall electronically maintain data on grievances/appeals in accordance with the requirements outlined in this section, to include, but not be limited to: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; date of review or review meeting; resolution information for each level of grievance or appeal, if applicable; date of resolution at each level, if applicable; and resulting corrective action.	P/P for monthly reporting of grievances and appeals including sample report format	Full			
13.3.3	The MCO will be responsible for promptly	P/P for Adverse	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	forwarding any adverse decisions to DHH for further review/action upon request by DHH or the MCO member. DHH may submit recommendations to the MCO regarding the merits or suggested resolution of any grievance/appeal.	Decisions				
13.4						
13.4.1	**General Requirements** In handling grievances and appeals, the MCO must meet the following requirements:					
13.4.1.1	Acknowledge receipt of each grievance and appeal in writing within five (5) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the monthly grievance log;	P/P for Grievances P/P for Appeals Acknowledgement Letter Template Includes Member Grievance File and Member Appeal File Review	Full			
13.4.1.2	Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability;	P/P for Grievances P/P for Appeals	Full			
13.4.1.3 13.4.1.3.1 13.4.1.3.2 13.4.1.3.3	Ensure that the individuals who make decisions on grievances and appeals are individuals: • who were not involved in any previous level of review or decision-making; nor a subordinate of any such individual; • who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as	P/P for Grievances P/P for Appeals Includes Member Grievance File and Member Appeal File Review	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	determined by LDH, in treating the member's condition or disease: o an appeal of a denial that is based on lack of medical necessity, o a grievance regarding denial of expedited resolution of an appeal, o a grievance or appeal that involves clinical issues. • Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial action.					
13.4.2	**Special Requirements for Appeals** The process for appeals must:					
13.4.2.1	Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal). The member, member's authorized representative or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. Unless the member requests an expedited appeal, the oral appeal shall be confirmed in writing.	P/P for Appeals Member Handbook Confirmation Letter Template	Full			
13.4.2.2	Provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The MCO must inform the member of the limited time available for this sufficiently in advance of the date by which the MCO shall resolve the appeal in the case	P/P for Appeals Member Handbook Process for notifying member of opportunity to provide evidence		Full		

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of expedited resolution).	Includes Member Appeals File Review				
13.4.2.3	Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process and any evidence considered, relied upon, or generated by the MCO in connection with the appeal. This information shall be provided free of charge and sufficiently in advance of the date by which the MCO shall resolve the appeal.	P/P for Appeals Member Handbook Process for notifying member of opportunity to examine case file Includes Member Appeals File Review		Full		
13.4.2.4	Include, as parties to the appeal: the member and his or her representative; or the legal representative of a deceased member's estate.	P/P for Appeals Member Handbook Includes Member Appeals File Review		Full		
13.4.3	**Training of MCO Staff** The MCO's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers.	Training Agendas and attachments Sign-in sheets	Full			
13.4.4	**Identification of Appropriate Party** The appropriate individual or body within the MCO having decision making authority as part of the grievance/appeal procedure shall be identified.	Name and title of individual or name of body having decision-making authority Job description for individual having decision-making authority	Full			
13.4.5	**Failure to Make a Timely Decision**	P/P for Appeals	Substantial	Full	This requirement is	

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Appeals shall be resolved no later than stated time frames and all parties shall be informed of the MCO's decision. If a determination is not made in accordance with the timeframes specified, the member's request will be deemed to exhaust the MCO's appeal process as of the date upon which a final determination should have been made. The member may then initiate a State Fair Hearing.		This requirement is partially addressed in the Member Appeals–- Core Process – LA Policy on page 4. **<u>Recommendation</u>** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. <u>MCO Response:</u> Member Appeals – Core Process Policy, number 5, page 4 of 16 **<u>Final Review Determination</u>** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.		addressed in the Member Appeals–- Core Process – LA Policy on page 4.	
13.4.6	**Right to State Fair Hearing** The MCO shall inform the member of their right to seek a State Fair Hearing if the member is not satisfied with the MCO's decision in response to an appeal and the process for doing so.	P/P for Appeals P/P for Fair Hearing Appeal Resolution Notice	Full			
13.5	**Notice of Action**					
13.5.1	**Language and Format Requirements** The notice must be in writing and must meet the language and format requirements of 42 C.F.R. §438.10 and Section 12 of this RFP to ensure ease of understanding.	Notice of Action Includes Member Grievance File And Member Appeal File Review	Full			
13.5.2	**Content of Notice of Action** The Notice of Action must explain the following:					

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.5.2.1	The action the MCO or its contractor has taken or intends to take;	P/P for Notice of Action Notice of Action Includes Member Grievance File and Member Appeals File Review	Full			
13.5.2.2	The reasons for the action; including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review	Full			
13.5.2.3	The member's right to file an appeal with the MCO;	P/P for Notice of Action Notice of Action Review	Full			
13.5.2.4	The member's right to request a State Fair Hearing, after the MCO's appeal process has been exhausted;	P/P for Notice of Action Notice of Action Includes Member Appeal File Review	Full			
13.5.2.5	The procedures for exercising the rights specified in this section;	P/P for Notice of Action Notice of Action	Full			
13.5.2.6	The circumstances under which expedited appeal is available and how to request it;	P/P for Notice of Action	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Notice of Action				
13.5.2.7	The member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and	P/P for Notice of Action Notice of Action Includes Member Appeal File Review	Full			
13.5.2.8	Availability of interpretation services for all languages and how to access them.	P/P for Notice of Action Notice of Action	Full			
13.5.3	**Timing of Notice of Action** The MCO must mail the Notice of Action within the following timeframes:					
13.5.3.1	For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least ten (10) days before the date of action,:	P/P for Notice of Action	Full			
13.5.3.2	In cases of verified member fraud, or when LDH has facts indicating that action should be taken because of probable member fraud at least five (5) days before the date of action;	P/P for Notice of Action	Full			
13.5.3.3	By the date of action for the following: • In the death of a recipient; • If the member submits a signed written recipient statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information); • The recipient’s admission to an institution	P/P for Notice of Action	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	where he is eligible for further services; • The recipient's address is unknown and mail directed to him has no forwarding address; • The recipient has been accepted for Medicaid services by another local jurisdiction; or • The recipient's physician prescribes the change in the level of medical care; or • As otherwise permitted under 42 CFR §431.213.					
13.5.3.4	For denial of payment, at the time of any action affecting the claim according to the terms and conditions outlined in the contract between the provider and the individual MCO.	P/P for Notice of Action	Full			
13.5.3.5 13.5.3.5.1 13.5.3.5.2	For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if: • The member, or the provider, acting on behalf of the member and with the member's written consent, requests extension; or • The MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Action P/P for Notice of Action for Standard Service Authorizations P/P for Handling Extensions Notice of Decision to Extend Timeframe	Full			
13.5.3.6	If the MCO extends the timeframe in accordance with above, it must: • Make reasonable efforts to give the	P/P for Notice of Action P/P for Handling	Full			

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Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member prompt oral notice of the delay; • Within two (2) days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision, and • Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.	Extensions Notice of Decision to Extend Timeframe Includes Member Appeal File Review				
13.5.3.7	On the date the timeframe for service authorization as specified expires. Untimely service authorizations constitute a denial and are thus adverse actions.	P/P for Notice of Action	Full			
13.5.3.8	For expedited service authorization decisions where a provider indicates, or the MCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision 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.	P/P for Notice of Action P/P for Notice of Action for Expedited Service Authorizations	Full			
13.5.3.9	The MCO may extend the seventy-two (72) hours time period by up to fourteen (14) calendar days if the member requests an extension, or if the MCO justifies (to DHH upon request) a need for additional information and how the extension is in the member's interest.	P/P for Notice of Action P/P for Handling Extensions Notice of Decision to Extend Timeframe	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
13.5.3.10	DHH will conduct random reviews to ensure that members are receiving such notices in a timely manner.					
13.6	**Resolution and Notification**					
13.6	The MCO must dispose of a grievance and resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, within the timeframes established below.	P/P for Grievances P/P for Appeals	Full			
13.6.1	**Specific Timeframes**					
13.6.1.1	**Standard Disposition of Grievances** For standard disposition of a grievance and notice to the affected parties, the timeframe is established as ninety (90) days from the day the MCO receives the grievance.	P/P for Grievances Includes Member Grievance File Review	Full			
13.6.1.2	**Standard Resolution of Appeals** For standard resolution of an appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the MCO receives the appeal. This timeframe may be extended under Section 13.6.1.2 of this Section.	P/P for Appeals Includes Member Appeals file review	Substantial This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 3 and the member handbook, Grievances and Medical Appeals, on page 55. **Appeals File Review Results** Eight (8) of 10 appeals files reviewed were compliant. **Recommendation for Healthy Blue** The MCO should ensure that appeals are resolved according to contractual requirements of 30 days. MCO Response: Staff training was conducted with ongoing monthly monitoring by internal accreditation staff.	Full	This requirement is addressed in the Member Appeals–- Core Process – LA Policy on page 3. **Appeals File Review Results** Ten (10) of 10 appeals files reviewed were compliant.	
13.6.1.3	**Expedited Resolution of Appeals** For expedited resolution of an appeal and notice to affected parties, the timeframe is	P/P for Appeals Includes Member	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	established as seventy-two (72) hours after the MCO receives the appeal. This timeframe may be extended under Section 13.6.2 of this Section.	Appeals File Review				
13.6.2.1	**Extension of Timeframes** The MCO may extend the timeframes from Section 13.6.1 of this Section by up to fourteen (14) calendar days if: • The member requests the extension; or • The MCO shows (to the satisfaction of DHH, upon its request) that there is need for additional information and how the delay is in the member's interest.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeals File Review	Full			
13.6.2.2	**Requirements Following Timeframe Extension** If the MCO extends the timeframes, it must, for any extension not requested by the member: • Give the member written notice of the reason for the delay. • Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	P/P for Appeals P/P for Grievances P/P for Handling Extensions Notice of Decision to Extend Timeframe Includes Member Appeals File Review	Substantial This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 14. **<u>Recommendation for Healthy Blue</u>** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. **<u>Appeals File Review Results</u>** Two (2) of 2 appeals files reviewed were compliant. Eight (8) files were NA. <u>MCO Response:</u> Member Appeals – Core Process Policy, Extending Decision Timeframe, page 13-14 of 16 **<u>Final Review Determination</u>** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next	Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 14. **<u>Appeals File Review Results</u>** None of the appeals files reviewed had extended timeframes therefore this was not applicable.	

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			compliance review.			
13.6.3	In the case of an MCO that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's appeal process and may initiate a state fair hearing.	P/P for Appeals	Substantial Member Appeals – Core Process – LA Policy on page 9. **<u>Recommendation for Health Blue</u>** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. <u>MCO Response:</u> Member Appeals – Core Process Policy, number 5, page 4 of 16 **<u>Final Review Determination</u>** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Full	This requirement is addressed in the Member Appeals – Core Process – LA Policy on page 8.	
13.6.4 13.6.4.1 13.6.4.2	**Format of Notice of Disposition** **Grievances.** The MCO will provide written notice to the member of the disposition of a grievance. **Appeals.** For all appeals, the MCO must provide written notice of disposition. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.	P/P for Grievances P/P for Appeals Resolution Notice	Full			
13.6.5 13.6.5.1 13.6.5.2	**Content of Notice of Appeal Resolution** The written notice of the resolution must include the following: the results of the resolution process and the date it was completed.	P/P for Appeals Resolution Notice	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	For appeals not resolved wholly in favor of the members: the right to request a State Fair Hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the MCO's action.					
13.6.6	**Requirements for State Fair Hearings** The MCO shall comply with all requirements as outlined in this RFP.					
13.6.6.1	**Availability.** If the member has exhausted the MCO-level appeal procedures, the member may request a State Fair Hearing within one hundred twenty (120) days from the date of the MCO's notice of resolution. The member may also initiate a State Fair Hearing following deemed exhaustion of appeals processes.	P/P for Appeals P/P for Fair Hearings	Full			
13.6.6.2	**Parties.** The parties to the State Fair Hearing include the MCO as well as the member and his or her representative or the representative of a deceased member's estate.	P/P for Fair Hearings	Full			
13.7	**Expedited Resolution of Appeals**					
13.7.0	The MCO must establish and maintain an expedited review process for appeals, when the MCO determines (for a request from the member) or the provider, acting on behalf of the member and with the member's written consent, indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a	P/P for Appeals	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.					
13.7.1	**Prohibition Against Punitive Action** The MCO must ensure that punitive action is not taken against a provider, acting on behalf of the member and with the member's written consent, who requests an expedited resolution or supports a member's appeal.	P/P for Appeals Provider Handbook	Full			
13.7.2	**Action Following Denial of a Request for Expedited Resolution** If the MCO denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the timeframe for standard resolution; • Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice. • This decision (i.e., the denial of a request for expedited resolution of an appeal) does not constitute an Action or require a Notice of Action. The Member may file a grievance in response to this decision.	P/P for Appeals Denial Notice	Full			
13.7.3	**Failure to Make a Timely Decision** Appeals shall be resolved no later than above stated timeframes and all parties shall be informed of the MCO's decision in writing. If a determination is not made by the above timeframes, the member's request will be deemed to have exhausted the MCO's appeal process as of the date	P/P for Appeals	Substantial This requirement is partially addressed in the Member Appeals –Core Process – LA Policy on page 4. **<u>Recommendation</u>** A revision to the policy was made after the review period. The MCO should finalize the revision to the	Full	This requirement is addressed in the Member Appeals –Core Process – LA Policy on page 4.	

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	upon which a final determination should have been made.		policy that includes the updated language. <u>MCO Response:</u> Member Appeals – Core Process Policy, number 5, page 4 of 16 **<u>Final Review Determination</u>** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.			
13.7.4 13.7.4.1	**Process** The MCO is required to follow all standard appeal requirements for expedited requests except where differences are specifically noted in the requirements for expedited resolution. The member or provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional follow-up may be required.	P/P for Appeals	Full			
13.7.4.2	The MCO shall inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of expedited resolution.	Process for notifying member of opportunity to present evidence	Full			
13.7.5	**Authority to File** The Medicaid member or their provider, acting on behalf of the member and with the member's written consent, may file an expedited appeal either orally or in writing. No additional member follow-up is required.	P/P for Appeals	Full			
13.7.6	**Format of Resolution Notice** In addition to written notice, the MCO must	P/P for Appeals	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	also make reasonable effort to provide oral notice.	Includes Member Appeal File Review				
13.8	**Continuation of Benefits**					
13.8.1	Terminology - As used in this section, “timely'' filing means filing on or before the later of the following: within ten (10) days of the MCO mailing the notice of action or the intended effective date of the MCO's proposed action.					
13.8.2	**Continuation of Benefits** The MCO must continue the member's benefits if: The member or the provider, acting on behalf of the member and with the member's written consent, files the appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii); • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; • The services were ordered by an authorized provider; • The original period covered by the original authorization has not expired; and • The member requests extension of benefits.	P/P for Continuation of Benefits Process for notifying member of continuation of benefits	Full			
13.8.3	**Duration of Continued or Reinstated Benefits** If the MCO continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal; • Ten (10) days pass after the MCO mails	P/P for Continuation of Benefits Process for notifying member of continuation of benefits	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached; • A State Fair Hearing Officer issues a hearing decision adverse to the member; • The time period or service limits of a previously authorized service has been met.					
13.8.4	**Member Responsibility for Services Furnished While the Appeal is Pending** If the final resolution of the appeal is adverse to the member, that is, upholds the MCO's action, the MCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section, and in accordance with the policy set forth in 42 C.F.R. § 431.230(b).	P/P for Continuation of Benefits Process for notifying member of continuation of benefits	Full			
13.9	**Information to Providers and Contractors**					
13.9.0	The MCO must provide the information specified at 42 C.F.R. § 438.10(g) (2)(xi) about the grievance system to all providers and contractors at the time they enter into a contract.	Provider Manual/Handbook Provider Contract Contractor Contract	Full			
13.10	**Recordkeeping and Reporting Requirements**					
13.10.0	Reports of grievances and resolutions shall be submitted to DHH as specified in Section 13.4 and of this RFP. The MCO shall not modify the grievance procedure without the	P/P for Grievances P/P for reporting grievances and resolutions to DHH	Full			

Member Grievances and Appeals						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438. 400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	prior written approval of DHH.	Report Format				
13.11	**Effectuation of Reversed Appeal Resolutions**					
13.11.1	**Services not Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the decision..	P&P for effectuation of reversed appeal resolutions	Substantial This requirement is addressed in the Member Appeals – Core Process –- LA Policy on page 13. **Recommendation** A revision to the policy was made after the review period. The MCO should finalize the revision to the policy that includes the updated language. MCO Response: Member Appeals – Core Process Policy, Continuation of Benefits, page 12-13 of 16. **Final Review Determination** No change in review determination. The language was added to the policy after the review period. This policy can be submitted for review for the next compliance review.	Full	This requirement is addressed in the Member Appeals –Core Process – LA Policy on page 13.	
13.11.2	**Services Furnished While the Appeal is Pending** If the MCO or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO must pay for those services, in accordance with this Contract.	P&P for effectuation of reversed appeal resolutions	Full			

Provider Network Requirements

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.1	**General Provider Network Requirements**					
7.1.1	The MCO shall maintain and monitor a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under this contract for all members, including those with limited English proficiency or physical or mental disabilities.					
7.1.2	The MCO must maintain a network that ensures, at minimum, equal access to qualified providers as the rest of the insured population in the area. [42 CFR 438.210.(a)(2)]	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.1.3	All services covered under this contract shall be accessible to MCO members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Full			
7.1.4	Network providers must be available within a reasonable distance to members and accessible within an appropriate timeframe to meet the members' medical needs. Standards for distance and time are fully outlined in this Section and in the Provider Network Companion Guide. The MCO shall ensure that providers are available in network within the distance requirements set forth in this Section.	Network Provider Development and Management Plan P/P for Provider Network P/P for Access and Availability	Full			
7.1.5	If the MCO is unable to provide the necessary services to a member within their network, the MCO must adequately and timely cover these services out of network. The MCO shall ensure coordination with respect to authorization and payment issues in these circumstances [42 CFR §438.206.(b)(4) and (5)].	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.1.7	The MCO's network providers shall ensure physical	P/P for Provider Network	Substantial	Full	This requirement is	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.	P/P for Access and Availability	This requirement is partially addressed in the Model Facility Agreement, Physician and Ancillary agreements that discuss the cultural competency requirements. However, this language should be included in the provider manual also. **<u>Recommendation</u>** The MCO should include language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities in the provider manual. <u>MCO Response:</u> Healthy Blue will add language on ensuring physical accessibility and accessible equipment for Medicaid members with physical or mental disabilities to the provider manual. The next round of provider manual updates will take place this fall, with an updated manual being made available to providers in January 2020.		addressed in the Provider Manual and LA Provider Enterprise Agreement. This addresses the recommendation from the prior review.	
7.1.8	At the request of the member, the MCO shall provide for a second opinion from a network provider, or arrange for the member to obtain one outside the network, at no cost to the member.	P/P for Provider Network P/P for Access and Availability	Full			
7.1.9	The MCO and its providers shall deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity and provide for cultural competency and linguistic needs, including the	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook Provider contracts	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member's prevalent language(s) and sign language interpreters in accordance with 42 CFR §438.206(c)(2). MCOs must ensure that effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs are provided. Assurances shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclo1.9se this information, it cannot be required); • Assessing the cultural competency of the providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.2	**Appointment Availability Access Standards**					

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.2.1	The following appointment availability standards have been established as minimum requirements to ensure that members' needs are sufficiently met. LDH will monitor the MCO's compliance with these standards through regular reporting as shown in Provider Network Companion Guide. The MCO shall ensure that appointments with qualified providers are on a timely basis, as follows:					
7.2.1.1	Emergent or emergency visits immediately upon presentation at the service delivery site. Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of request;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.2	Urgent Care within twenty-four (24) hours. Provisions must be available for obtaining urgent care, including behavioral health care, 24 hours per day, 7 days per week. Urgent care may be provided directly by the PCP or directed by the MCO through other arrangements. An appointment shall be arranged within forty-eight (48) hours of request;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.3	Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or emergency condition;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.4	Routine, non-urgent, or preventative care visits within 6 weeks. For behavioral healthcare, routine, non-urgent appointments shall be arranged within fourteen (14) days of referral;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.5	Specialty care consultation within one (1) month of referral or as clinically indicated;	P/P for Provider Network P/P for Provider Appointment	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Standards Provider Handbook/Manual Provider contracts Member Handbook				
7.2.1.6	Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated; and	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.7	Maternity Care - Initial appointment for prenatal visits for newly enrolled pregnant women shall meet the following timetables from the postmark date the MCO mails the member's welcome packet for members whose basis of eligibility at the time of enrollment in the MCO is pregnancy. The timeframes below apply for existing members or new members whose basis of eligibility is something other than pregnancy from the date the MCO or their subcontracted provider becomes aware of the pregnancy: within their first trimester within 14 days; within the second trimester within 7 days; within their third trimester within 3 days; high risk pregnancies within 3 days of identification of high risk by the MCO or maternity care provider, or immediately if an emergency exists;	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Substantial Although this requirement is addressed in the provider manual on page 14, the language in the member handbook does not fully address this requirement. Page 12 of the member handbook states that new members follow the timelines listed in the requirement, but not current members identified as pregnant within the first or second trimester. This was discussed on-site with the provider network management staff and it was clarified that the policy applies to both new and existing members as written in the provider agreement and is addressed with providers in the provider manual. **Recommendation** The MCO should update the language in the member handbook to show the requirement timeline addresses both new and current members newly identified as pregnant.	Full	This requirement is addressed in the member handbook on page 21. This addresses the recommendation from the prior review.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response: Healthy Blue will update language in the member handbook to show the requirement timeline addresses both new and current members newly identified as pregnant. The next round of member handbook updates will be completed by Q4 2019.			
7.2.1.8	Follow-up to ED visits in accordance with ED attending provider discharge instructions.	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.2.1.9 7.2.1.10 7.2.1.11 7.2.1.12	In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room. If a provider is delayed, patients shall be notified immediately. If the wait is anticipated to be more than 90 minutes, the patient shall be offered a new appointment. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.	P/P for Provider Network P/P for Provider Appointment Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
7.3	**Geographic Access Requirements**					
7.3.0	The MCO shall comply with the following travel time and/or distance requirements, as specified in the Provider Network Companion Guide. Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests should include data on the local provider population available to the non-Medicaid population. If LDH approves the	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	exception, the MCO shall monitor member access to the specific provider type on an ongoing basis and provide the findings to LDH as part of its annual Network Provider Development Management Plan.					
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers .3 Travel distance for members living in rural parishes shall not exceed 30 miles; and .4 Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan. In review of the 220 HBL Report, distance requirements are met for all rural parishes, but not for all urban parishes for both adult and adolescent primary care providers. **Recommendation** The MCO should improve access to PCPs for their urban members. MCO Response: As of July 2019 Adult Urban access is 97.8% and Pediatric Urban access is 98.4%; The Network team is working currently working with 3 large urban PCP groups to be added to our Network. • 348 HBL 2019 Q2 cover 348 HBL 2019 Q2 (Full Report)	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. **Recommendation** The MCO should improve access to PCPs for their urban members.	Healthy Blue will request exceptions for the following Parishes: Plaquemines, East & West Feliciana, Union, and Grant. For other deficient parishes the Network team will continue contracting efforts, if needed more exceptions will be requested.
7.3.2 7.3.2.1 7.3.2.2	Acute Inpatient Hospitals • Travel distance for members living in rural parishes shall not exceed 30 miles; If no hospital is available within 30 miles of a member's residence, the MCO may request, in writing, an exception to this requirement. • Travel distance for members living in urban parishes shall not exceed 10 miles.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan. The MCO provided 220 HBL Reports. The Q4 2018 report indicates that distance requirements are mostly met for rural parishes, but they are not met for all urban parishes.	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response: HBL currently has ALL acute care hospitals located in the state under contract. **Final Review Determination** No change in review determination. As per the language of the contract, it states that travel distance shall not exceed 10 miles for all urban members. There may be a lack of hospitals in certain areas, which can pose as a limitation to the MCO meeting this requirement.		The state is considering whether it is appropriate to modify its contract requirements.	
7.3.3 7.3.3.1 7.3.3.2 7.3.3.3 7.3.3.4	Specialists • Travel distance to each specialty type shall not exceed 60 miles for at least 75% of members; and • Travel distance shall not exceed 90 miles for all members. • Specialists included under this requirement are listed the Provider Network Companion Guide.. LDH reserves the right to add additional specialty types as needed to meet the medical needs of the member population. • Telemedicine may be used to facilitate access to specialists to augment MCO's network or to meet specific needs of a subset of the MCO's membership. If an MCO intends to utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan in Access to Specialists. In review of the 220 HBL reports, all the MCO's specialties (except ob/gyn) meet the access standard for accessibility within 90 miles. All specialties (except ob/ gyn) meet the requirement that at least 75% of members have access to the specialty in a 60-mile distance, and all members have access to specialists within 90 miles. As listed in the Provider Network Development Plan, access to ob/gyns should not exceed 30 miles in rural parishes and shall not exceed 15 miles in urban parishes. Not all urban and rural parishes meet this requirement. **Recommendation** The MCO should improve access to ob/gyns for their rural and urban	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance requirements were not met for: Allergy/immunology (exceeds 90 miles) Dermatology (exceeds 90 miles) Endocrinology and metabolism (exceeds 90 miles) Hematology/oncology (exceeds 90 miles) **Recommendation** The MCO should improve access for	The Template during the look back period was locked and could not be adjusted to include the 90 mile data. The change in the 220 report was as of 2/2019. Amendment # 3 from LDH has now corrected the template to align with the contract language. If you would like, HB can have Geo Access maps created to show adequacy of 100% within 90 miles.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			members. <u>MCO Response:</u> Currently HBL as 96.4% Urban and 95.4% rural access for OBGYN; Many Parishes in Louisiana do not have Hospitals and/or Hospitals that offer OB Services. • 348 HBL 2019 Q2 cover 348 HBL 2019 Q2 (Full Report)		allergy/immunology, dermatology, endocrinology and metabolism and hematology/oncology specialties.	
7.3.4 7.3.4.1 7.3.4.2	Lab and Radiology Services • Travel distance shall not exceed 20 miles in urban parishes; and • Travel distance shall not exceed 30 miles for rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development Plan. In review of the 220 HBL Geo Access Report, all key geographic urban and rural areas meet the standard for accessibility. Most, but not all, of the other urban and rural parishes meet this requirement. **<u>Recommendation</u>** The MCO should improve access to lab services for all rural and urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language. <u>MCO Response:</u> Overall, HBL has 98.9% urban and 99.9% rural lab access; Network will target these area to improve access; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **<u>Recommendation</u>** The MCO should improve access to lab and radiology services for members in urban parishes.	For Lab services, Healthy Blue will work with the provider community to include office with CLIA certifications. For Radiology services, Healthy Blue continue contracting efforts with free standing imaging facilities and/or request exceptions from LDH for area without these services.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			• 348 HBL 2019 Q2 (Full Report)			
7.3.5 7.3.5.1 7.3.5.2	Pharmacies .3 Travel distance shall not exceed 10 miles in urban parishes; and .4 Travel distance shall not exceed 30 miles in rural parishes.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development. The Q4 2018 Reports indicate that distance requirements are met for rural parishes, but not for all urban parishes. **<u>Recommendation</u>** The MCO should improve access to pharmacies for all urban members. The MCO should update the Provider Network Development Plan to include the access standard requirement language. <u>MCO Response:</u> Overall, HBL has 98.3% urban and 100% Rural access. Network will work with our PBM to improve access in needed areas; The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover • 348 HBL 2019 Q2 (Full Report)	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **<u>Recommendation</u>** The MCO should improve access to pharmacies for members in urban parishes.	Healthy Blue will work with our Pharmacy vendor to ensure compliance. A logic correction was implemented and future report will show compliance.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers .3 Travel distance shall not exceed 10 miles in urban areas; and .4 Travel distance shall not exceed 30 miles in rural areas.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is not referenced in the Provider Network Development Plan. Most, but not all, urban and rural parishes meet the access standard for hemodialysis centers. **<u>Recommendation</u>** The MCO should improve access to pharmacies for all urban members. The	Substantial	This requirement is addressed in 220 HBL 2019 SA2. Distance and/or time requirements were met for rural but not urban parishes. **<u>Recommendation</u>**	HB will request exceptions from LDH for Hemodialysis centers within the deficient parishes. Hemodialysis network participation is challenged with 3 main barriers: Lack of Hemodialysis providers within the state of Louisiana.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO should update the Provider Network Development Plan to include the requirement language. MCO Response: Overall, HBL 90.1% urban and 98.4% rural; The state has a limited number of these facilities and will work to improve the network. The contract Geo Access language can be added to the Network Development plan. • 348 HBL 2019 Q2 cover 348 HBL 2019 Q2 (Full Report)		The MCO should improve access to hemodialysis centers for members in urban parishes.	Healthy Blue has contracts with all the National Providers and all but a few independent providers. The national hemodialysis companies have in the past purchased independent providers and closed the less profitable. The mile/minute requirements very narrow for such specialized services with such limited access.
7.3.7 7.3.7.1	**Specialized Behavioral Health Providers** Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or Clinical Nurse Specialist (CNS) in mental health, or LCSW's) and to psychiatrists for members living in rural parishes shall not exceed 30 miles or 60 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.2	Travel distance to behavioral health specialists (i.e., psychologists, medical psychologists, APRN Nurse Practitioner or CNS in mental health, or LCSW's) and to psychiatrists for members living in urban parishes shall not exceed 15 miles or 30 minutes for 90% of such members.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is referenced in the Provider Network Development Plan, and 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for behavioral health specialists and psychiatrists are met for rural parishes and mostly met for urban parishes. **Recommendations** The MCO should improve access to behavioral health specialists for all urban members.	Full	This requirement is addressed in 348 2020 Q1 miles and minutes. Distance and/or time requirements were met for behavioral health specialists.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response: Overall HBL has a 98.9% urban access for BH Specialists and will continue to improve access by contracting any available BH Specialists.			
7.3.7.3	Travel distance to psychiatric inpatient hospital services shall not exceed 90 miles or 90 minutes for 90% of members. Maximum time for admission shall not exceed 4 hours (emergency involuntary), 24 hours (involuntary), or 24 hours (voluntary).	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial The requirement language is missing from the Provider Network Development Plan. 348 HBL Reports were provided for review. Q4 2018 348 HBL Reports show that access standards for inpatient psychiatric hospitals are met for rural parishes and urban parishes. **Recommendation** The MCO should include the requirement language in the Provider Network Development Plan. MCO Response: The health plan follows requirements of the Provider Network Companion Guide. **Final Review Determination** No change in review determination. It is understood the plan follows the Provider Network Companion guide but the language should be included in the Provider Network Development Plan (as seen for the other provider type standards).	Full	This requirement is addressed in 348 2020 Q1 miles and minutes. Distance and/or time requirements were met for psychiatric inpatient hospital services.	
7.3.7.4	Travel distance to ASAM Level 3.3 shall not exceed 30 miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		GeoAccess reports Requests for exceptions				
7.3.7.5	Travel distance to ASAM Level 3.5 shall not exceed 30 miles or 60 minutes for 90% of adult members and shall not exceed 60 miles or 90 minutes for adolescent members. Maximum time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.6	Travel distance to ASAM Level 3.7 co-occurring treatment shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximus time for admission or appointment shall not exceed 10 business days.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.7	Travel distance to ASAM Level 3.7WM shall not exceed 60 miles or 90 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days. Withdrawal management shall be available within 24 hours when medically necessary.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.8	Travel distance to Psychiatric Residential Treatment Facilities (PRTF) shall not exceed 200 miles or 3.5 hours for 100% of members. Maximum time for admission shall not exceed 20 calendar days. Access and adequacy is based on availability of in-state PRTFs unless the MCO provides evidence that indicates an out-of-state provider is clinically appropriate to treat the specific needs of the member.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			
7.3.7.9	Request for exceptions as a result of prevailing community standards for time and distance accessibility standards must be submitted in writing to LDH for approval.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.3.7.10	There shall be no penalty if the member chooses to travel further than established access standards in order to access a preferred provider. The member shall be responsible for travel arrangements and costs.	P/P Access standards Member handbook	Full			
7.4.1	**Provider to Member Ratios** The MCO must demonstrate that their network has a sufficient number of providers and facilities to meet minimum ratio requirements and allow adequate access for members. Adequate ratios of providers to members can be found in the Provider Network Companion Guide.	Network Provider Development and Management Plan P/P for Access and Availability Evidence of meeting provider to member ratios	Full			
7.5	**Monitoring and Reporting on Provider Networks**					
7.5.1 7.5.1.1 7.5.1.2	Appointment Availability Monitoring • The MCO shall have written policies and procedures about educating its provider network about appointment time requirements. The MCO must include their appointment standards in the Provider Manual and shall disseminate appointment standards and procedures to its members and include this information on their website. The MCO is encouraged to include the standards in the provider subcontracts. • The MCO is responsible for monitoring and assurance of provider compliance with appointment availability standards and provision of appropriate after-hour coverage.	Network Provider Development and Management Plan Provider contracts Provider manual/handbook P/P for Access and Availability P/P for Monitoring Provider Compliance with Access Standards Plan website Evidence that monitoring was implemented	Full			
7.5.2 7.5.2.1 7.5.2.2 7.5.2.3	**Geographic Availability Monitoring** The MCO shall submit quarterly GeoAccess reports documenting the geographic availability of network providers including PCPs, hospitals, pharmacies, and each specialty type listed the Provider Network Companion Guide. The attestation included with this report shall provide narrative identifying any gaps in coverage and the corrective measures that	GeoAccess reports Communication to LDH/ attestation	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	will address them. The data in the quarterly GeoAccess reports shall be current, accurate, and consistent with provider registry data submitted to LDH by the plans as required in the **MCO Systems Companion Guide.** The MCO report on accessibility shall include assessment of coverage including distance, population density, and provider availability variables. All gaps in coverage must be identified and addressed in the Network Development Plan.					
7.5.3 7.5.3.1 7.5.3.2	**Provider to Member Ratios** • Quarterly GeoAccess reports shall include analysis of provider-to-member ratios in each geographical area as outlined in this Section and the Provider Network Companion Guide. • Member linkages to Primary Care providers shall be submitted to LDH weekly as described in the MCO Systems Companion Guide.	GeoAccess reports Communications to LDH	Full			
7.6	**Provider Enrollment**					
7.6.1	**Provider Participation -**	Provider contracts Network Provider Development and Management Plan P/P for Provider Network	Full			
7.6.1.6	The MCO must offer a Contract to the following providers: • Louisiana Office of Public Health (OPH); • all OPH-certified School Based Health Clinics (SBHCs); • all small rural hospitals meeting the definition in the Rural Hospital Preservation Act of 1997; • Federally Qualified Health Centers (FQHCs); • Rural Health Clinics (RHCs) (free-standing and	Network Provider Development and Management Plan P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	hospital based); • Clinics and outpatient providers funded under the HRSA administered Ryan White HIV/AIDS Program. • The MCO shall make a reasonable effort to contract with all local family planning clinics and providers, including those funded by Title X of the Public Health Services Act services; and • All providers approved by the LDH PSH program to provide tenancy and pre-tenancy supports for the Louisiana Permanent Supportive Housing program. • Local Governing Entities; • Methadone Clinics pending CMS approval; Providers of addiction services for youth and adults at all levels of care (i.e., ASAM Levels 1, 2.1, 2-WM, 3.1, 3.2-WM, 3.3, 3.5, 3.7, 3.7-WM, 4-WM); • Providers of Evidenced Based Practices (EBPs), i.e. Assertive Community Treatment (ACT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT) and Homebuilders®; • Providers trained to implement specialized behavioral health services for the at-risk youth population age zero (0) – age six (6) [e.g. Parent Child Interaction Therapy (PCIT), Child-Parent Psychotherapy (CPP) and Parent Management Training (PMT)]; • All current Psychiatric Residential Treatment Facilities (PRTFs) and Therapeutic Group Homes (TGHs); • Current LMHPs (Psychologists, LCSW, LPC, LMFT, LAC, APRNs).					
7.6.1.7	The MCO shall make a good faith effort to execute a contract with significant traditional providers (STPs). In the event an agreement cannot be	Network Provider Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	reached and a STP does not participate in the MCO, the MCO shall maintain documentation detailing efforts that were made.	P/P for Provider Network				
7.6.1.8	If a current Medicaid provider requests participation in an MCO, the MCO shall make a good faith effort to execute a contract. In the event an agreement cannot be reached and the provider does not participate in the MCO, the MCO has met this requirement; the MCO shall maintain documentation detailing efforts made.	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.6.1.9	The provisions above do not prohibit the MCO from limiting provider participation to the extent necessary to meet the needs of the MCO's members. These provisions also do not interfere with measures established by the MCO to control costs and quality consistent with its responsibilities under this contract nor does it preclude the MCO from using reimbursement amounts that are the greater than the published Medicaid fee schedule for different specialists or for different practitioners in the same specialty [42 CFR 438.12(b)(1)].	Network Provider Development and Management Plan P/P for Provider Network	Full			
7.6.1.10	If the MCO declines requests of individuals or groups of providers to be included in the MCO network, the MCO must give the requested providers written notice of the reason for its decision within fourteen (14) calendar days of its decision [42 CFR 438.12(a)(1)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention Evidence of timely notice of denied provider requests for participation Sample notice to providers	Full			
7.6.1.11	The MCO shall work with LDH and other MCOs to convene local/regional forums to explore care coordination and care integration and build partnerships with providers.	P/P care coordination Meeting/Forum Meetings	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.6.1.12	The MCO shall comply with any additional requirements established by LDH.					
7.6.2 7.6.2.1	Exclusion from Participation - The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act [42 CFR 438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/, and Health Integrity and Protection Data Bank at http://www.npdb-hipdb. hrsa.gov/index.jsp.	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Credentialing P/P for Provider Selection and Retention	Full			
7.6.2.2 7.6.2.2.1 7.6.2.2.2 7.6.2.2.3 7.6.2.2.4 7.6.2.2.5 7.6.2.2.6	The MCO shall not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to Section 1128 (42 U.S.C. §1320a-7) or Section 1156 (42 U.S.C. §1320c- 5) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. This includes providers undergoing any of the following conditions identified through LDH proceedings: .1 Revocation of the provider's home and community-based services license or behavioral health service license; .2 Exclusion from the Medicaid program; .3 Termination from the Medicaid program; .4 Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41);	P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	.5 Provider fails to timely renew its home and community-based services license as required by the Home and Community-Based Services providers Licensing Standards Rule (LAC 48:I.Chapter 50); or .6 The Louisiana Attorney General's Office has seized the assets of the service provider.					
7.6.2.3	The MCO shall not remit payment for services provided under this contract to providers located outside of the United States. The term "United States" means the fifty (50) states, the District of Columbia, and any U.S. territories.	P/P for Provider Network	Full			
7.6.3 7.6.3.1	Other Enrollment and Disenrollment Requirements - The MCO shall not discriminate with respect to participation in the MCO program, reimbursement or indemnification against any provider solely on the provider's type of licensure or certification [42 CFR 438.12(a)(1)] The MCO shall establish and follow a documented process for credentialing and re-credentialing of network providers [42 CFR §438.12(a)(2).In addition, the MCO must not discriminate against particular providers that service high-risk populations or specialize in conditions that require costly treatment [42 CFR 438.214(c)].	Network Provider Development and Management Plan P/P for Provider Network P/P for Provider Selection and Retention P/P for Provider Credentialing	Full			
7.6.3.2	All providers shall be in compliance with American with Disabilities Act (ADA) requirements and provide physical access for Medicaid members with disabilities.	Network Provider Development and Management Plan P/P for Provider Network Provider manual/handbook P/P for Provider Credentialing	Full			
7.6.3.4	If the MCO terminates a provider's contract for cause, the MCO shall provide immediate written notice to the provider within one (1) business day	P/P for Provider Network P/P for Provider Termination Sample notice to providers	Substantial In the Provider Network Development Plan, on page 24, it states that the MCO	Substantial	This requirement is addressed in the Timely Notification of	The Network development plan has been updated and

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of the decision being made. The notice shall be through electronic means followed by a certified letter mailed within one (1) business day. The MCO shall notify LDH through email prior to provider notification.	Sample notice to LDH	will provide immediate notification to the provider and notify LDH of the termination after the written notification to the provider soon after, but no later than 7 calendar days. This is not in line with current requirement language. However, the provider termination process was discussed on-site with staff, who stated that termination notices are sent out immediately or as soon as a decision has been reached on a provider's status and LDH has been informed of providers that should be terminated for cause. A sample provider termination letter was provided after the on-site. A sample email to LDH notifying them of all provider termination letters was also provided. Additionally, the standard Report 145 HBL lists the names of providers who are terminated for cause. **Recommendation** The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language. MCO Response: Timely Notification of Participating Provider Termination policy, # 4 Page 6 of 8 **Final Review Determination** No change in review determination.		Participating Provider Termination-LA Policy and Procedure on page 2. An edit has been made addressing this requirement but was made after the review period on 8/3/20. **Recommendation** Recommendation is unchanged from prior year. The MCO should update its Provider Termination Policy and Provider Network Development Plan to include the requirement language.	will be submitted to LDH for approval. The policy has been updated.

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.			
7.6.3.5	If termination affects network adequacy, the MCO shall include in the notification to LDH their plans to notify MCO members of such change and strategy to ensure timely access for MCO members through different in-network and/or out-of network providers. If termination is related to the MCO's operations, the notification shall include the MCO's plan for how it will ensure there will be no stoppage or interruption of services to members.	P/P for Provider Network P/P for Provider Termination Sample notice to members	Full			
7.6.3.6	The MCO shall make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each MCO member who received his or her care from or was seen on a regular basis by the terminated provider as specified in 42 CFR §438.10(f)(1) within the past two years.	P/P for Provider Network P/P for Provider Termination Sample notice to members Member Handbook	Substantial The requirement language is partially addressed in the Timely Notification of Participating Provider Termination Policy. As discussed at the on-site audit, termination processes and member notifications are coordinated simultaneously. **Recommendation** The MCO should update the Timely Notification of Participating Provider Termination Policy to include the	Full	This requirement is address in Timely Notification of Participating Provider Termination – LA Policy and Procedure on page 5.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			criterion of MCO members who have received care "within the past two years." MCO Response: Timely Notification of Participating Provider Termination – LA; # a Page 6 **Final Review Determination** No change in review determination. Based on the response provided by Healthy Blue, we found this information in the rebuttal document Timely Notification of Participating Provider Termination policy given to IPRO in response to our recommendation; however this is not the same documentation of the same name that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the policy with the added language for the next audit review.			
7.15.1	The MCO must designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including re-credentialing files). The credentialing committee, including the Medical Director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files. A physician must oversee the credentialing committee.	P/P for credentialing committee. P/P for credentialing decisions Credentialing committee minutes	New Requirement	Full	This requirement is addressed in credentialing policy (A3 – Cred Pol_3v7_11020.pdf)	
7.7	**Mainstreaming**					
7.7.1	LDH considers mainstreaming of MCO members into the broader health delivery system to be	Provider contracts Provider Handbook/Manual	Substantial This requirement is partially addressed in	Substantial	This requirement is met by the Provider	The Mainstreaming language was added to the

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	important. The MCO therefore must ensure that all MCO providers accept members for treatment and that MCO providers do not intentionally segregate members in any way from other persons receiving services.		the provider manual on page 65. The meaning of the requirement is addressed on pages 14 and 15 that services should not be administered to members in any way different from the public or those providers should not show preference to other insured or private-pay patients. However, the provider contracts do tell providers that they must not discriminate members based on sex, race, creed, and other discriminating factors, such as a person's status as a program contract beneficiary. **Recommendation** The MCO should define mainstreaming appropriately within the Provider Manual as well as communicate mainstreaming requirements in their various provider contracts. MCO Response: Healthy Blue will define mainstreaming appropriately within the Provider Manual. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.		Handbook on page 70. However this version of the provider manual was drafted after the review period 6.18.20. **Recommendation** The MCO should include in the next provider manual the relevant statements found on page 70 of the 6.18.20 draft Provider Manual.	previous version of the Provider Manual, as reflected in our prior submission of the draft manual to IPRO. The manual, with the language incorporated, is still with LDH for review. Upon their approval, this document will be posted to the web portal as well.
7.7.2	To ensure mainstreaming of members, the MCO shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin	Provider contracts Provider Handbook/Manual Member Handbook	Substantial The requirement is partially addressed in the provider contracts in the Non-discrimination. section.	Substantial	This requirement is met by the provider manual on page 70. However, this version of the	The Mainstreaming language was added to the previous version of the Provider Manual, as

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	ancestry, marital status, sexual preference, health status, income status, program membership, or physical, behavioral, or cognitive disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:		**Recommendation** The MCO should indicate in their provider contract(s) and provider manual that they will take affirmative action to mainstream and ensure members are provided covered services without discrimination. MCO Response: Healthy Blue will indicate in the provider manual that we will take affirmative action to mainstream and ensure members are provided covered services without discrimination. The next round of provider updates will take place this fall, with an updated provider manual being made available to providers in January 2020. Through the contract the provider manual is made a part of the contract thru binding language.		Provider Manual was drafted after the review period 6.18.20. **Recommendation** The MCO should include in the next provider manual the relevant statements found on page 70 of the 6.18.20 draft provider manual.	reflected in our prior submission of the draft manual to IPRO. The manual, with the language incorporated, is still with LDH for review. Upon their approval, this document will be posted to the web portal as well.
7.7.2.1	Denying or not providing to a member any covered service or availability of a facility.	Provider contracts Provider Handbook/Manual	Full			
7.7.2.2	Providing to a member any covered service which is different, or is provided in a different manner, or at a different time from that provided to other members, other public or private patients, or the public at large.	Provider contracts Provider Handbook/Manual	Full			
7.7.2.3	Discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay or Medicaid fee-for-service patients.	Provider contracts Provider Handbook/Manual	Full			
7.7.3	When the MCO becomes aware of a specialized behavioral health provider's failure to comply with mainstreaming, the MCO shall develop a written	P/P provider contracts Provider Contract Provider Handbook	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	plan for coming into compliance with the Contract requirement for mainstreaming with the behavioral health provider within thirty (30) calendar days and notify LDH in writing					
7.7.4	The MCO shall ensure that providers do not exclude treatment or placement of members for authorized behavioral health services solely on the basis of state agency (DCFS or OJJ, etc.) involvement or referral.	P/P provider contracts Provider Contract Provider Handbook	Full			
7.8.2	**Primary Care Provider Responsibilities**					
7.8.2.0	The MCO must ensure that network Primary Care Providers fulfill their responsibilities including but not limited to the following:					
7.8.2.1	Managing and coordinating the medical and behavioral health care needs of members to assure that all medically necessary services are made available in a timely manner;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.2	Referring patients to subspecialists and subspecialty groups and hospitals as they are identified for consultation and diagnostics according to evidence-based criteria for such referrals as it is available;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.3	Communicating with other levels of medical care to coordinate, and follow up the care of individual patients;	P/P for PCP responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.4	Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services available through fee-for-service Medicaid;	P/P for PCP responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.5	Maintaining a medical record of all services rendered by the PCP and record of referral to other providers and any documentation provided by the rendering provider to the PCP for follow up and/or coordination of care;	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined	P/P for PCP Responsibilities Provider Handbook/Manual	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	in Section 6.33.	Provider contracts				
7.8.2.7	Ensuring that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR Parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information and all state statutes.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.8	Providing after-hours availability to patients who need medical advice. At minimum, PCP office must have a return call system staffed and monitored in order to assure that the member is connected to a designated medical practitioner within 30 minutes of the call.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.9	Maintaining hospital admitting privileges or arrangements with a physician who has admitting privileges at an MCO participating hospital.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.10	Working with MCO case managers to develop plans of care for members receiving case management services.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.11	Participating in the MCO's case management team, as applicable and medically necessary.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.2.12	Conducting screens for common behavioral issues, including but not limited to depression, anxiety, trauma/adverse childhood experiences (ACEs), and substance use, to determine whether the member needs behavioral health services.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
7.8.3 7.8.3.1	**Specialty Providers** The MCO shall assure access to specialty providers, as appropriate, for all members. The MCO shall assure access standards and guidelines to specialty providers are met as specified in this Section in regard to timeliness and service area.					
7.8.3.2	The MCO provider network shall include	P/P for Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	P/P for Access to Specialty Providers GeoAccess reports				
7.8.3.3	The MCO shall ensure access to appropriate service settings for members needing medically high risk perinatal care, including both prenatal and neonatal care.	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports	Substantial The requirement language is not in the Provider Network Development Plan. However, the Q2 2018 Geo Access Report indicates 95.8% of urban parish members have access to an ob/gyn in a 15-mile radius and 95.4% of rural parish members have access to an ob/gyn provider in a 30-mile radius. **Recommendation** The MCO should include this language in their Provider Network Development Plan. MCO Response: Network Development Plan, Section 7.8.3.3, page 30 **Final Review Determination** No change in review determination. The rebuttal version of the Network Development Plan document, which was provided in response to our recommendation, is not the same documentation that was provided to IPRO for the pre-onsite review. The MCO should provide the revised version of the document with the added language for the next audit review.	Full	This requirement is address in the provider network development and management plan Jan 2020. This addresses the recommendation from the prior review.	

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.8.3.4	The MCO shall establish and maintain a provider network of physician specialists that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members (adults and children) without excessive travel requirements. This means that, at a minimum: • The MCO has signed a contract with providers of the specialty types listed in the Provider Network Companion Guide who accept new members and are available on at least a referral basis; and • The MCO is in compliance with access and availability requirements	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports Evidence of signed contracts with listed specialty provider types	Full			
7.8.3.5	The MCO shall assure, at a minimum, the availability of the specialists listed in the Provider Network Companion Guide with the ratio, distance, and appointment time requirements set in this Section and in the Provider Network Companion Guide.					
7.8.3.6	The MCO will be required to provide a higher ratio of specialists per member population and/or additional specialist types/member ratios may be established, if it is determined by LDH the MCO does not meet the access standards specified in the Contract.	P/P for Provider Network P/P for Access to Specialty Providers	Full			
7.8.3.7	In accordance with 42 CFR §438.208(c)(4), for enrollees determined to need a course of treatment or regular monitoring, the MCO must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs.	P/P for Provider Network P/P for Access to Specialty Providers P/P for direct access services	Full			
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All					

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.					
7.8.4.2 7.8.4.2.1 7.8.4.2.2	The MCO shall include, at a minimum, access to the following: .1 One (1) hospital that provides emergency room services, inpatient, and outpatient care in each parish in the state, provided the parish has such a hospital. .2 MCO must establish access to the following within their network of hospitals: • Level III Obstetrical services; • Level III Neonatal Intensive Care (NICU) services; • Pediatric services; • Trauma services; • Burn services; and • A Children's Hospital that meets the CMS definition in 42CFR, Parts 412 and 413.	P/P for Provider Network GeoAccess reports	Full			
7.8.4.3	The MCO may contract with out-of-state hospitals in the trade area.	P/P for Provider Network GeoAccess reports	Full			
7.8.4.4	If there are no hospitals within the parish that meet these requirements in section 7.8.4.2.1 or a contract cannot be negotiated, the MCO may contract with out-of-state hospitals to comply with these requirements.	P/P for Provider Network GeoAccess reports	Full			
7.8.5	**Tertiary Care** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists; these services frequently require complex technological and support facilities. The MCO shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-	P/P for use of out-of-network providers P/P for providing access to tertiary care GeoAccess reports	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	specialists available twenty-four (24) hours per day. If the MCO does not have a full range of tertiary care services, the MCO shall have a process for providing such services including transfer protocols and arrangements with out-of-network providers.					
7.8.6	**Direct Access to Women's Health Care** The MCO shall provide direct access to a health specialist(s) in-network for core benefits and services necessary to provide women's routine and preventive health care services. This access shall be in addition to the member's PCP if that provider is not a women's health specialist.	P/P for direct access services	Full			
7.8.6.1	The MCO shall demonstrate its network includes sufficient family planning providers to ensure timely access to covered services.	P/P for direct access services	Full			
7.8.6.2	The MCO shall notify and give each member, including adolescents, the opportunity to use their own PCP or utilize any family planning service provider for family planning services without requiring a referral or authorization. Family planning services shall be available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments and traditional contraceptive devices. The MCO family planning services shall also include preconception and interconception care services for members to optimize member health entering pregnancy. The MCO shall agree to make available all family planning services to MCO members as specified in this RFP.	P/P for direct access services Member Handbook	Full			
7.8.6.3	MCO members shall have the freedom to receive family planning services and related supplies from appropriate Medicaid providers outside the MCO's provider network without any restrictions as specified in 42 CFR §431.51(b)(2). The out-of-	P/P for direct access services Member Handbook	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	network Medicaid enrolled family planning services provider shall bill the MCO and be reimbursed no less than the Medicaid rate in effect on the date of service. MCO members should be encouraged by the MCO to receive family planning services through the MCO's network of providers to ensure continuity and coordination of the member's total care. No additional reimbursements shall be made to the MCO for MCO members who elect to receive family planning services outside the MCO's provider network.					
7.8.6.5	The MCO shall maintain the confidentiality of family planning information and records for each individual member including those of minor patients.	P/P for Direct Access Services	Full			
7.8.7 7.8.7.1	**Prenatal Care Services** The MCO shall assist all pregnant members in choosing a pediatrician, or other appropriate PCP, for the care of their newborn babies before the beginning of the last trimester of gestation. In the event that the pregnant member does not select a pediatrician, or other appropriate PCP, the MCO shall provide the member with a minimum of fourteen (14) calendar days after birth to select a PCP prior to assigning one.	P/P for Prenatal Care Services Access P/P for Assignment of PCPs including Auto Assignment	Full			
7.8.8	**Other Service Providers** The MCO shall ensure the availability of medical service providers including, but not limited to, ambulance services, durable medical equipment, orthotics, prosthetics and certain supplies, and radiology, and laboratories. All services must be provided in accordance with applicable state and federal laws and regulations.	Evidence of availability of other medical service providers	Full			
7.8.10 7.8.10.1	**FQHC/RHC Clinic Services** The MCO must offer to contract with all FQHCs and	P/P for Provider Network Contracts with FQHC/RHCs	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	RHCs (both freestanding and hospital-based) in the state.					
7.8.11 7.8.11.1	**School-Based Health Clinics (SBHCs)** SBHC (certified by the LDH Office of Public Health) services are those Medicaid services provided within school settings to Medicaid eligible children under the age of 21.					
7.8.11.2	The MCO must offer a contract to each SBHC. The MCO may stipulate that the SBHC follow all of the MCO's required policies and procedures.	P/P for Provider Network Contracts with SBHCs	Full			
7.8.13 7.8.13.1	**Local Parish Health Clinics** The MCO must offer a contract to the Louisiana Office of Public Health (OPH) for the provision of personal health services offered within the parish health units (e.g. immunizations, STI, family planning).	P/P for Provider Network Contract with Louisiana OPH	Full			
7.8.13.2	The MCO shall coordinate its public health-related activities with OPH. Coordination mechanisms and operational protocols for addressing public health issues shall be negotiated with OPH and BHSF (Medicaid) and reflect Louisiana public health priorities. The coordination of activities related to public health will take the form of agreements among the parties which may include policy memos or separate memorandums of understanding signed by OPH, BHSF (Medicaid), and the MCO.	P/P for Provider Network Contract with Louisiana OPH	Full			
7.8.14 7.8.14.1	**Specialized Behavioral Health Providers** The MCO shall ensure behavioral health services are offered to address the needs of youth with serious emotional disorders, adults with Serious Mental Illness (SMI), members with substance use disorders, members with co-occurring mental health and substance use disorders and other developmental disorders. This shall include coordination with the Local Governing Entities	P/P provider network P/P care coordination Network reports	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	(LGEs) for the provision of Medicaid services.					
7.8.14.2	The MCO shall ensure its provider network offers a range of preventive and specialized behavioral health services as reflected in the LDH Behavioral Health Provider Manual and meets the network adequacy standards defined in this contract. The provider network shall be adequate for the anticipated number of members for the service area. The service array shall comply with the waivers and Medicaid State Plan requirements.					
7.8.14.3	The network shall be developed to meet the needs of members, including but not limited to providing assessment to identify and treat the behavioral health needs of members with past history or current display of aggression, runaway behavior, sexual offenses, or intellectual disability.		Full			
7.8.14.4	The MCO shall design its provider network to maximize the availability of community-based behavioral healthcare that reduces utilization of emergency services when lower cost community-based services are available and eliminates preventable hospital admissions. The MCO shall coordinate with other state agencies, as appropriate, to match services to meet behavioral health needs in the community with services and supports to meet the members other needs in the community, such as I/DD.		Full			
7.8.14.5	The MCO shall design its provider network to increase the emerging use of peers as providers. This includes peers providing services for youth, adults and parents/families served in community and residential settings, peer services as approved by LDH as cost-effective alternative services, and peer support specialists with OBH approved credentials to serve as qualified providers.	P/P provider network P/P care coordination Network reports	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.8.14.6	The MCO shall ensure that within the provider network, members enrolled in 1915(c) CSoC Home and Community Based waiver services have a choice of behavioral health providers, which offer the appropriate level of care and may change providers in accordance with Medicaid home and community based waiver requirements pertaining to Freedom of Choice.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.7	The MCO shall ensure the provider network has a sufficient number of prescribers and other qualified behavioral health service providers to deliver services during evenings and weekends.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.8	The MCO shall have a fully operational network of behavioral health crisis response providers offering a complete array of crisis services, available twenty-four (24) hours per day, seven (7) days per week. Crisis services shall include an on-call, 24-hour crisis hotline, warm line, crisis counseling crisis intervention and follow up, linkage to ongoing behavioral health management and intervention, mobile crisis teams, and crisis stabilization for children. The MCO may also coordinate with community resources to expand the crisis response. The community-based crisis response system may include, but is not limited to, warmlines, mobile crisis teams, collaboration with law enforcement crisis stabilization in alternative settings, and crisis stabilization/crisis receiving centers for adults. If shortages in provider network sufficiency are identified by LDH, the MCO shall conduct outreach efforts approved by LDH, and take necessary actions to assure member access to medically necessary behavioral health services. The MCO shall execute an ad hoc or single case agreement when a	P/P provider network P/P care coordination Network reports	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	clinical need or a specialized behavioral health service is identified for a member and no network provider is available to meet that particular need. In such cases, all transportation necessary to receive necessary services will be provided and reimbursed through the MCO, including meals and lodging as appropriate.					
7.8.14.10	The MCO shall require behavioral health providers to screen for basic medical issues.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.11	The MCO shall monitor and support development of local provider capacity for the purpose of identifying and filling gaps in service availability.	P/P provider network P/P care coordination Network reports	Full			
7.8.14.12	The MCO shall report the number of out-of-state placements as specified by LDH. LDH may require the MCO to take corrective action in the event LDH determines the MCO's rate of out of state placements to be excessive.	P/P provider network P/P care coordination	Full			
7.8.15 7.8.15.1	**Indian Health Care providers (IHCPs)** The MCO shall demonstrate that there are sufficient IHCPs participating in the provider network of the MCO to ensure timely access to services available under the contract from such providers for Indian members who are eligible to receive services.	P/P provider network P/P care coordination Network reports	Full			
7.8.15.2 7.8.15.2.1 7.8.15.2.2 7.8.15.2.3	The IHCPs, whether participating in the MCO network or not, shall be paid for covered services provided to Indian members who are eligible to receive services from such providers as follows: • At a rate negotiated between the MCO and the IHCP; or • In the absence of a negotiated rate, at a rate not less than the level and amount of payment that the MCO would make for the services to a participating provider which is not an IHCP; and					

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.					
7.8.15.3	The MCO shall permit any Indian who is enrolled with the MCO and is eligible to receive services from an IHCP primary care provider participating as a network provider, to choose that IHCP as his or her PCP, as long as that provider has capacity to provide the services.		Full			
7.8.15.4	The MCO shall permit Indian members to obtain services covered under the contract from out-of-network IHCPs from whom the member is otherwise eligible to receive such services.		Full			
7.8.15.5 7.8.15.5.1 7.8.15.5.2	Where timely access to covered services cannot be ensured due to few or no IHCPs, the MCO will be considered to have met the requirement in paragraph 42 CFR §438.14 (b)(1) if: .1 Indian members are permitted by the MCO to access out-of-state IHCPs; or .2 If this circumstance is deemed to be good cause for disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).	P/P provider network P/P care coordination Network reports	Substantial The first bulleted requirement is communicated to members in the member handbook. The second bulleted requirement is not listed specifically in the Provider Network Development Plan. **<u>Recommendation</u>** The MCO should add the language pertaining to timely access to IHCPs specifically addressed in the Provider Network Development Plan. <u>MCO Response:</u> Network Development Plan, Indian Health Care Providers (IHCPs) , Page 35-36.	Full	This requirement is addressed in the Provider Network Development and Management Plan Jan 2020 on page 41. The MCO has addressed the prior recommendation.	
7.8.15.6	The MCO shall permit an out-of-network IHCP to refer an Indian member to a network provider.	P/P provider network P/P care coordination Network reports	Full			
7.9	**Network Provider Development Management Plan**					

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.9.1	The MCO shall develop and maintain a Provider Network Development and Management Plan which ensures that the provision of core benefits and services will occur [42 CFR 438.207(b)]. The Network Development and Management Plan shall be submitted to LDH as part of the proposal, as well as when significant changes occur and annually thereafter. The Network Development and Management Plan shall include the MCO's process to develop, maintain and monitor an appropriate provider network that is supported by written agreements and is sufficient to provide adequate access of all required services included in the Contract. When designing the network of providers, the MCO shall consider the following (42 CFR 438.68):	Provider Network Development and Management Plan	Full			
7.9.1.1	Anticipated maximum number of Medicaid members;	Provider Network Development and Management Plan	Full			
7.9.1.2	Expected utilization of services, taking into consideration the characteristics and health care needs of the members in the MCO;	Provider Network Development and Management Plan	Full			
7.9.1.3	The numbers and types (in terms of training, experience, and specialization) of providers required to furnish Medicaid core benefits and services;	Provider Network Development and Management Plan	Full			
7.9.1.4	The numbers of MCO providers who are not accepting new MCO members; and	Provider Network Development and Management Plan	Full			
7.9.1.5	The geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for Medicaid enrollees with disabilities.	Provider Network Development and Management Plan	Full			
7.9.2	The Network Provider Development and	Provider Network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Development and Management Plan				
7.9.2.1	Assurance of Adequate Capacity and Services and supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards for access to care, including the standards at 42 CFR §438.68 and 438.206(b)	Provider Network Development and Management Plan	Full			
7.9.2.2	Assurance it offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members in the service area;	Provider Network Development and Management Plan	Full			
7.9.2.3	Access to Primary Care Providers	Provider Network Development and Management Plan	Full			
7.9.2.4	Access to Specialists	Provider Network Development and Management Plan	Full			
7.9.2.5	Access to Hospitals	Provider Network Development and Management Plan	Full			
7.9.2.6	Access to Behavioral Health Services	Provider Network Development and Management Plan	Full			
7.9.2.7	Timely Access	Provider Network Development and Management Plan	Full			
7.9.2.8	Service Area	Provider Network Development and Management Plan	Full			
7.9.2.9	Other Access Requirements: • Direct Access to Women's Health , • Special Conditions for Prenatal Providers, • Second Opinion	Provider Network Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	• Out-of-Network Providers					
7.9.3	The Network Provider Development and Management Plan shall identify gaps in the MCO's provider network and describe the process by which the MCO shall assure all covered services are delivered to MCO members. Planned interventions to be taken to resolve such gaps shall also be included. The MCO shall include the corrective action(s) taken when a network provider fails to comply with timely access requirements.	Provider Network Development and Management Plan	Full			
7.9.3.1	The MCO shall ensure network capacity sufficient to meet the specialized needs of individuals with dual diagnosis of behavioral health and developmental disabilities, including autism spectrum disorders. The plan shall specifically assess the extent to which the MCO's in-state network is sufficient to meet the needs of this population.	Provider Network Development and Management Plan	Full			
7.9.3.2	Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified in the provider directory.	Provider Network Development and Management Plan Provider Directory	Full			
7.9.4	The MCO shall provide GEO mapping and coding of all network providers for each provider type by the deadline specified in the Schedule of Events, to geographically demonstrate network capacity. The MCO shall provide updated GEO coding to LDH quarterly, or upon material change (as defined in the Glossary) or upon request.	Provider Network Development and Management Plan GeoAccess reports	Full			
7.9.5	The MCO shall develop and implement Network Development policies and procedures detailing how the MCO will [42 CFR 438.214(a)]:					
7.9.5.1	Communicate and negotiate with the network regarding contractual and/or program changes and requirements;	P/P for Network Development and Management	Full			
7.9.5.2	Monitor network compliance with policies and rules	P/P for Network Development	Full			

Provider Network Requirements						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	of LDH and the MCO, including compliance with all policies and procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	and Management				
7.9.5.3	Evaluate the quality of services delivered by the network;	P/P for Network Development and Management	Full			
7.9.5.4	Provide or arrange for medically necessary covered services should the network become temporarily insufficient within the contracted service area;	P/P for Network Development and Management	Full			
7.9.5.5	Monitor the adequacy, accessibility and availability of its provider network to meet the needs of its members, including the provision of care to members with limited proficiency in English; and	P/P for Network Development and Management	Full			
7.9.5.6	Process expedited and temporary credentials. Recruit, select, credential, re-credential and contract with providers in a manner that incorporate quality management, utilization, office audits and provider profiling;	P/P for Network Development and Management	Full			
7.9.5.7	Provide training for its providers and maintain records of such training;	P/P for Network Development and Management	Full			
7.9.5.8	Track and trend provider inquiries/complaints/requests for information and take systemic action as necessary and appropriate;	P/P for Network Development and Management	Full			
7.9.5.9	Ensure that provider complaints are acknowledged within 3 business days of receipt; resolve and/or state the result communicated to the provider within 30 business days of receipt (this includes referrals from LDH). If not resolved in 30 days the MCO must document why the issue goes unresolved; however, the issue must be resolved within 90 days.	P/P for Network Development and Management	Full			
7.9.6	An evaluation of the initial Network Provider Development and Management Plan, including evaluation of the success of proposed interventions	P/P for Evaluation of Network Provider Development and Management Plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	and any needed revisions, shall be submitted to LDH at the end of the first year of operations and annually thereafter.					
7.9.7	MCO Network Development and Management policies shall be subject to approval by LDH, Medicaid Managed Care Section and shall be monitored through operational audits.	Evidence of submission of P/P for Network Development and Management to LDH	Full			
7.9.8	**Specialized Behavioral Health Network Development and Management Plan** An initial Network Development and Management Plan focusing on specialized behavioral health providers shall be submitted to LDH by November 1, 2015. Thereafter, the Specialized Behavioral Health network shall be included in a distinct section of the overall MCO Network Development and Management Plan which shall be updated at least annually or more often as needed to reflect material changes in network status.	Network development Implementation plan P/P provider network	Full			
7.9.8.1	The plan shall contain separate sections for each specialized behavioral health provider type for all covered specialized behavioral health services for both children and adults, and satisfy all service delivery requirements described in this contract	Network development Implementation plan P/P provider network	Full			
7.9.8.2	The MCO's Network Development and Management Plan shall include the following requirements for specialized behavioral health providers: • The methodology the MCO will use for the evaluation of specialized behavioral health providers' ability to perform activities associated with this contract;	Network development Implementation plan P/P provider network	Full			
	• The numbers and types (in terms of training, experience, and specialization) of specialized behavioral health providers required to furnish the contracted specialized behavioral health	Network development Implementation plan P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);					
	• GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate network capacity. The MCO shall provide updated GEO mapping and coding to LDH quarterly by contract year, upon material change of the network, or upon request;	Network development Implementation plan P/P provider network	Full			
	• An annual needs assessment to identify unmet service needs in the specialized behavioral health service delivery system. The needs assessment shall analyze and include: • Volume of single case agreements and out-of-network, out-of-state and telemedicine referrals for specialized behavioral health services; • Specialized behavioral health service needs of members; and • Growth trends in eligibility and enrollment, including: o Current and anticipated numbers of Title XIX and Title XXI eligibles; and o Current and desired specialized behavioral health service utilization trends, including prevalent diagnoses, age, gender, and race/ethnicity characteristics of the enrolled population by region; best practice approaches; and network and contracting models consistent with LDH goals and principles.	P/P network Needs assessment findings	Full			
	• Accessibility of services, including: o The number of current qualified specialized	Network development Implementation plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	behavioral health service providers by individual specialized behavioral health service in the network who are not accepting new Medicaid referrals and a plan for updating on a regular, reoccurring basis as close to real time as possible; o The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; o Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and o Any service access standards detailed in a SPA or waiver.	P/P provider network				
7.9.8.3	The MCO shall submit to LDH as part of its annual Network Development and Management Plan, and upon request of LDH, specialized behavioral health provider profiling data, which shall include: • Member eligibility/enrollment data; • Specialized behavioral health service utilization data; • The number of single case agreements by specialized behavioral health service type; • Specialized behavioral health treatment and functional outcome data; • The number of members diagnosed with developmental/cognitive disabilities; • The number of prescribers required to meet specialized behavioral health members' medication needs; • The efforts given to recruit specialized behavioral health providers and specialty providers to address any unmet need; • Provider grievance, appeal and request for	Evidence of submission of network development Plan to LDH Network and development plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	arbitration data; and • Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.					
7.9.8.4	For adults, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that: • Includes qualified specialized behavioral health service providers and community resources designed and contracted to deliver specialized behavioral healthcare that is strength-based, community-based, and culturally competent; • Includes specific specialized behavioral health services for adults eligible for services as defined in this contract; • Is of sufficient size and scope to offer members a choice of providers for all covered specialized behavioral health services; • Makes uniformly available over time recognized EBPs, best practices and culturally competent services that promote resiliency through nationally recognized integrated service models; and • Provides adequate, proactive development and monitoring of community-based options that limit reliance on hospital based services.	Network development and management plan	Full			
7.9.8.5	For children, the MCO shall include in its Network Development and Management Plan strategies for continued transformation of the specialized behavioral health service delivery system into a comprehensive system that includes the above elements for adults as well as: • Includes specific specialized behavioral health	Network development and management plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	services for children; • Targets the development of family and community-based services for children/youth in out-of-home placements; • Increases access to family and community-based services, optimizing the use of natural and informal supports and reduces reliance on out-of- home placements; and • Provides adequate, proactive development and monitoring of in-state regional out-of-home options to serve the needs of youth in the state.					
7.9.8.6	The Network Development and Management Plan shall state that the MCO's provider network meets requirements with regard to cultural competence and linguistics as follows: Cultural competence and linguistic needs, including the member's prevalent language(s) and sign language in accordance with 42 CFR §438.206; Provides effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. This shall be achieved by: • Collecting member demographic data, including but not limited to ethnicity, race, gender, sexual orientation, religion, and social class, so that the provider will be able to respond appropriately to the cultural needs of the community being served (note: members must be given the opportunity to voluntarily disclose this information, it cannot be required); • Assessing the cultural competence of the	Network development and management plan	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	providers on an ongoing basis, at least annually; • Assessing member satisfaction of the services provided as it pertains to cultural competence at least annually. Assessment shall capture necessary demographics of the member including, but not limited to, race/ethnicity, age, gender, parish, etc.; • Assessing provider satisfaction of the services provided by the MCO at least annually; and • Requiring and providing training on cultural competence, including tribal awareness, (or obtaining proof of attendance at other trainings on cultural competence) to MCO staff and behavioral health network providers for a minimum of three (3) hours per year and as directed by the needs assessments.					
7.9.8.7	The Network Development and Management Plan shall be inclusive of an evaluation of the initial Network Development and Management Plan in each subsequent year, which shall include evaluation of the success of proposed interventions, barriers to implementation, and any needed revisions pertaining to the delivery of specialized behavioral healthcare.	Network development and management plan	Full			
7.11	**Material Change to Provider Network**					
7.11.1	The MCO shall provide written notice to LDH, no later than seven (7) business days of any network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or the provider, and such notice shall include the reason(s) for the proposed action. A material change is defined as one which affects, or can reasonably be foreseen to affect, the MCO's ability to meet the performance and network standards as described in the Contract,	Evidence of communications with LDH P/P provider contracting	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	including but not limited to the following: • Any change that would cause more than five percent (5%) of members within the service area to change the location where services are received or rendered. • A decrease in the total of individual PCPs by more than five percent (5%); • A loss of any participating specialist which may impair or deny the members' adequate access to providers; • A loss of a hospital in an area where another MCO hospital of equal service ability is not available as required by access standards specified in this RFP; or • Other adverse changes to the composition of the MCO which impair or deny the members' adequate access to providers.					
7.11.2	The MCO shall also submit, as needed, an assurance when there has been a significant change in operations that would affect adequate capacity and services. These changes would include, but would not be limited to, changes in value-added benefits and services, payments, or eligibility of a new population.	Evidence of communication with LDH P/P Provider network	Full			
7.11.3	When the MCO has advance knowledge that a material change will occur, the MCO must submit a request for approval of the material change in their provider network, including a copy of draft notification to affected members, sixty (60) days prior to the expected implementation of the change.	Request for approval communications Notification to Member	Full			
7.11.4	The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.	Request for approval	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
7.11.5	If LDH does not respond within thirty (30) days the request and the notice are deemed approved. A material change in the MCO's provider network requires thirty (30) days advance written notice to affected members. For emergency situations, LDH will expedite the approval process.					
7.11.6	The MCO shall notify the LDH/BHSF/Medicaid Managed Care Section within one (1) business day of the MCO becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, a provider dies, the provider moves from the service area and fails to notify the MCO, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include: • Information about how the provider network change will affect the delivery of covered services, and • The MCO's plan for maintaining the quality of member care, if the provider network change is likely to affect the delivery of covered services.	Notification to LDH P/P provider network	Full			
7.11.7	MCO's shall give hospitals and provider groups ninety (90) days' notice prior to a contract termination without cause. Contracts between the MCO and single practitioners are exempt from this requirement.	Provider contracts P/P provider contracting	Full			
7.11.8 7.11.8.1	As it pertains to a material change in the network for behavioral health providers, the MCO shall also: .1 Provide written notice to LDH, no later than seven (7) business days of any behavioral health network provider contract termination that materially impacts the MCO's provider network, whether terminated by the MCO or	Evidence of notifications P/P provider network	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	the provider, and such notice shall include the reason(s) for the proposed action. Material changes in addition to those noted in Section 7.11 include: • A decrease in a behavioral health provider type by more than five percent (5%); • A loss of any participating behavioral health specialist which may impair or deny the members' adequate access to providers; or • A loss of a hospital or residential treatment in an area where another provider of equal service ability is not available as required by access standards approved by LDH.					
7.11.8.2	The MCO shall provide or arrange for medically necessary covered services should the network become temporarily insufficient within a service area.	P/P provider network	Full			
7.11.8.3 7.11.8.3.1	When the MCO has advance knowledge that a material change will occur to its network of behavioral health providers, the MCO must submit a written request for approval of the material change in their provider network to LDH, including a copy of draft notification to affected members, sixty (60) calendar days prior to the expected implementation of the change. .1 The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them, including: • Detailed information identifying the affected provider; • Demographic information and number of members currently served and impacted by the event or material change, including the number	Request for approval letter	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of Medicaid members affected by program category; • Location and identification of nearest providers offering similar services; and • A plan for clinical team meetings with the member, his/her family/caregiver, and other persons requested by the member and/or legal guardian to discuss available options and revise the service plan to address any changes in services or service providers.					
7.11.8.4	If a provider loss results in a material gap or behavioral health network deficiency, the MCO shall submit to LDH a written plan with time frames and action steps for correcting the gap or deficiency within thirty (30) calendar days that includes the transitioning of members to appropriate alternative behavioral health service providers in accordance with the network notification requirements.	Written plan P/P provider network	Full			
7.11.8.5	The MCO shall track all members transitioned due to a subcontract's suspension, limitation, termination, or material change to ensure behavioral health service continuity and provide member information as requested by LDH (e.g., name, Title XIX or Title XXI status, date of birth, services member is receiving or will be receiving, name of new provider, date of first appointment, and activities to re-engage persons who miss their first appointment with the new provider).	Tracking report P/P service coordination	Full			
7.12	**Coordination with Other Service Providers**					
7.12.0	The MCO shall encourage network providers and subcontractors to cooperate and communicate with other service providers who serve Medicaid members. Such other service providers may include: Head Start programs; Healthy Start programs; Nurse Family Partnership; Early	P/P for Coordination with Other Service Providers	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Intervention programs; Aging and Disability Councils; Areas on Aging; and school systems. Such cooperation may include performing annual physical examinations for schools and the sharing of information (with the consent of the enrollee).					
7.13	**Provider Subcontract Requirements**					
7.13.2.2	The MCO provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	P/P for Network Management P/P for Provider Selection and Retention	Full			
7.14	**Credentialing and Re-credentialing of Providers and Clinical Staff**					
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12, §438.206, §438.214, §438.224, §438.230 and NCQA health plan Accreditation Standards for the review, credentialing and re-credentialing of licensed, independent providers and provider groups with whom it contracts or employs and with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the MCO selects and directs its members to see a specific provider or group of providers. These procedures shall be submitted to LDH within sixty (60) calendar days after contract amendment, when a change is made, and annually thereafter by contract year.	P/P for credentialing & recredentialing	Full			
7.14.1.1	Prior to contracting, the MCO shall credential providers to ensure provider facilities, organizations, and staff meet all qualifications and requirements established by LDH including but not limited to the Medicaid Behavioral Health Provider Manual, state and federal laws, and rules and regulations for all specialized behavioral health providers. MCO credentialing files on providers shall include verification of meeting said	P/P provider contracting	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	requirements. This shall include that agencies offering mental health rehabilitation services (CPST, PSR and/or CI), Assertive Community Treatment (ACT), PRTFs, TGHs and SUD residential treatment facilities to supply proof of accreditation by an LDH approved accrediting body, which shall be made part of the agency's credentialing file with the MCO. Agencies not accredited at the time of credentialing shall supply proof that the agency applied for accreditation and paid the initial application fee Agencies must present proof of full accreditation within eighteen (18) months following the initial contracting date with the MCO. Specialized behavioral health provider types required to be accredited by rule, regulation, waiver or State Plan Amendment (SPA) prior to contracting or prior to receiving Medicaid reimbursement, shall have proof of accreditation on file with the MCO. LDH approved national accrediting bodies include: • The Council on Accreditation (COA); • The Commission on Accreditation of Rehabilitation Facilities (CARF); or • The Joint Commission (TJC).					
7.14.2	The MCO shall use the Louisiana Standardized Credentialing Application Form (Appendix F) or Council for Affordable Quality Healthcare (CAQH) standardized credentialing form. The MCO must allow providers to use CAQH if available for their provider type.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review	Full			
7.14.3	The MCO shall utilize the current NCQA Standards and Guidelines for the Accreditation of MCOs for the credentialing and re-credentialing of licensed independent providers and provider groups with whom it contracts or employs and who fall within its scope of authority and action.	P/P for credentialing & recredentialing	Full			

Provider Network Requirements						
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7.14.4	If the MCO has NCQA health plan Accreditation those credentialing policies and procedures shall meet LDH's credentialing requirements.	P/P for credentialing & recredentialing	Full			
7.14.5	The MCO shall completely process credentialing applications from all types of provider types within sixty (60) calendar days of receipt of a completed credentialing application, including all necessary documentation and attachments, and a signed provider agreement. "Completely process" shall mean that the MCO shall:	P/P for credentialing & recredentialing P/P for subcontractor delegation and requirements Credentialing subcontractor contract Includes Credentialing/Recredentialing File Review	Full			
7.14.5.1	Review, approve and load approved applicants to its provider files in its claims processing system; and	P/P for credentialing & recredentialing	Full			
7.14.5.2	Submit on the weekly electronic Provider Directory to LDH or LDH's designee; or	P/P for credentialing & recredentialing Provider Directory Evidence of submission of the Provider Directory	Full			
7.14.5.3	Deny the application and assure that the provider is not used by the MCO.	P/P for credentialing & recredentialing	Full			
7.14.6	If the MCO has delegated credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the contract. The MCO must require that the subcontractor provide assurance that all licensed medical professionals are credentialed in accordance with LDH's credentialing requirements.	P/P for credentialing & recredentialing Delegation Contracts	Full			
7.14.7	The MCO shall not delegate credentialing of specialized behavioral health providers unless approved by LDH in advance.	P/P for credentialing & recredentialing	Full			
7.14.8	To the extent the MCO has delegated credentialing agreements in place with any approved delegated credentialing agency, the MCO shall ensure all	P/P for credentialing & recredentialing	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	providers submitted to the MCO from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.					
7.14.9	The MCO shall notify LDH when the MCO denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	P/P for credentialing & recredentialing	Full			
7.14.10	The process of periodic re-credentialing shall be completed at least once every three (3) years.	P/P for credentialing & recredentialing Includes Credentialing/Recredentialing File Review	Full			
7.14.11	The MCO shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers to assure compliance with the Contract. The policies and procedures should include but are not limited to the encouragement of applicable board certification.	P/P for credentialing & recredentialing	Full			
7.14.12	The MCO shall develop and implement a mechanism, subject to LDH approval, for reporting quality deficiencies which result in suspension or termination of a network provider/ subcontractor(s). This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	P/P for credentialing & recredentialing P/P for reporting provider quality deficiencies Documented process for reporting quality deficiencies resulting in suspension or termination Includes Credentialing/Recredentialing File Review	Full			
7.14.13	The MCO shall develop and implement a provider	P/P for credentialing &	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	dispute and appeal process, with LDH's approval, for sanctions, suspensions, and terminations imposed by the MCO against network provider/contractor(s) as specified in the Contract. This process shall be submitted for review and approval thirty (30) days from the date the Contract is signed and at the time of any change.	recredentialing P/P for provider dispute and appeal process Documented provider dispute and resolution process for sanctions, suspensions and terminations Evidence of timely process submission				
7.14.14	The State reserves the right to contract with a single Credential Verification Organization (CVO). If this option is pursued, MCOs and their subcontractors shall agree to use the CVO for the credentialing and recredentialing of all participating providers. The MCO will be given at least 90 days' notice before implementation of any CVO contract.					
7.16	**Provider-Member Communication Anti-Gag Clause**					
7.16.1	Subject to the limitations in 42 CFR §438.102(a)(2), the MCO shall not prohibit or otherwise restrict a health care provider acting within the lawful scope of practice from advising or advocating on behalf of a member, who is a patient of the provider, regardless of whether the benefits for such care or treatment are provided under the Contract, for the following:	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts	Full			.
7.16.1.1	The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts	Full			
7.16.1.2	Any information the member needs in order to decide among relevant treatment options;	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts	Full			
7.16.1.3	The risks, benefits and consequences of treatment or non-treatment; and	P/P for Communication of Anti-gag Clause	Full			

Provider Network Requirements						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.12, 438.102, 438.206, 438.207, 438.208, 438.210, 438.214, 438.230)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		Provider Handbook/Manual Provider contracts				
7.16.1.4	The member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts	Full			
7.16.1.5	Any MCO that violates the anti-gag provisions set forth in 42 U.S.C §438.102(a)(1) shall be subject to intermediate sanctions.					
7.16.1.6	The MCO shall comply with the provisions of 42 CFR §438.102(a)(1)(ii) concerning the integrity of professional advice to members, including interference with provider's advice to members and information disclosure requirements related to physician incentive plans.	P/P for Communication of Anti-gag Clause Provider Handbook/Manual Provider contracts Member Handbook	Full			

Quality Management

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.1	**Quality Assessment and Performance Improvement Program (QAPI)**					
14.1.1	The MCO shall establish and implement a Quality Assessment and Performance Improvement (QAPI) program, as required by 42 CFR §438.330(a)(1), to:					
14.1.1.2	Objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promote improved patient outcomes through monitoring and evaluation activities;	QAPI Program Description QAPI Work Plan	Full			
14.1.3	Incorporate improvement strategies that include, but are not limited to: performance improvement projects; medical record audits; performance measures; Plan-Do-Study-Act cycles or continuous quality improvement activities; member and/or provider surveys; and activities that address health disparities identified through data collection.	QAPI Program Description QAPI Work Plan	Full			
14.1.4	Detect and address underutilization and overutilization of services	QAPI Program Description QAPI Work Plan	Full			
14.1.6	The MCO shall establish a quality improvement strategy which includes at least three (3) non-medically indicated procedures for either prior authorization or nonpayment in specific populations. Multiple medical specialty recommendations on appropriate utilization of services can be found at www.choosingwisely.org/. The strategy will be reviewed and approved by LDH prior to initial implementation and prior to implementation of significant changes, defined as adding or deleting a procedure, to the strategy.	QAPI Program Description QAPI Work Plan	Full			
14.1.7	The MCO shall reduce underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women,	QAPI Program Description QAPI Work Plan	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	use of long acting reversible contraceptives, appropriate pain management approaches in patients with sickle cell disease, and behavioral therapy for ADHD and other disorders for children under age 6.					
14.1.8	The MCO shall reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than six years of age.	QAPI Program Description QAPI Work Plan	Full			
14.1.9	The MCO shall assess the quality and appropriateness of care furnished to enrollees with special health care needs.	QAPI Program Description QAPI Work Plan	Full			
14.1.10	The MCO shall promote the Louisiana Medicaid Electronic Health Records (EHR) Incentive Payment Program to further expand adoption and support contracted participating providers through provider education in the collection and reporting on CMS electronic Clinical Quality Measures.	QAPI Program Description QAPI Work Plan	Full			
14.1.11	The MCO shall collect data on race, ethnicity, primary language, disability, and geography (i.e., urban/rural). As part of the QAPI program description the MCO shall include the methodology utilized for collecting the data, as well as any interventions taken to enhance the accuracy of the data collected. The MCO shall have the ability to report all performance measures stratified by race, ethnicity, primary language, disability, and geography at the request of LDH.	QAPI Program Description QAPI Work Plan	Full			
14.1.12	The QAPI Program's written policies and procedures shall address components of effective healthcare management and define processes for ongoing monitoring and evaluation that will promote quality of care. High risk and high volume areas of patient care	QAPI Program Description QAPI Work Plan	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	should receive priority in selection of QAPI activities.					
14.1.13	The QAPI Program shall define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest level of success.	QAPI Program Description QAPI Work Plan	Full			
14.1.15	The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program. The role of the MCO's governing body shall include providing strategic direction to the QAPI Program, as well as ensuring the QAPI Program is incorporated into the operations throughout the MCO.	QAPI Program Description QAPI Work Plan	Full			
14.1.16	The MCO shall have sufficient mechanisms in place to solicit feedback and recommendations from key stakeholders, members and their families/caregivers, and providers and use feedback and recommendations to improve performance.	Feedback reports QAPI work plan	Full			
14.1.17	The MCO shall disseminate information about findings and improvement actions taken and their effectiveness to LDH and other key stakeholders as directed by LDH.	Evidence of submission to LDH	Full			
14.1.18	The MCO shall increase the alignment of assessment and treatment with best practice standards through policies including increasing the use of evidence- based behavioral therapies as the first-line treatment for ADHD for children younger than six years of age, and other methods to increase the alignment with best practices for ADHD care for all children and particularly for children under age six.	Clinical guidelines for ADHD Provider education Provider manual	Full			
14.1.19	The MCO shall conduct peer review to evaluate the clinical competence and quality and appropriateness of care/services provided to members.	P/P provider oversight Peer review reports	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.1.20	The MCO shall participate in the LDH Interdepartmental Monitoring Team (IMT) meetings and other quality improvement-related meetings/workgroups, as directed by LDH.	IMT meeting minuets	Substantial This requirement is addressed in the Intervention Tracking Measure (ITM) Workgroup meeting notes for March 21, 2019, and in the Quality Meeting Participation document. The MCE submitted PDSA worksheets and run chart for all ITM workgroup meetings, except for the meeting on October 4, 2018, which the plan did not attend due to all PIP staff attending the NCQA Conference, with advance notice to IPRO and LDH on 9/20/18. **<u>Recommendation</u>** Healthy Blue should ensure that at least one representative is available to attend all PIP meetings, and submit all requested monitoring documentation for each meeting. <u>MCO Response:</u> Healthy Blue will ensure that a representative is present at all IMT and QM meetings moving forward and documentation is submitted. **Final Review**	Full	This requirement is addressed in the PIP meeting notes that Healthy Blue provided from January and March of 2020.	

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Determination: No change in determination. The plan agreed to the recommendation moving forward.			
14.1.21	The MCO shall report the percentage of members who are receiving behavioral health services whose clinical functioning is assessed over time (via clinician and/or member/family ratings on standardized tools, and/or measurable functional outcomes) to measure positive outcomes of service delivered. At a minimum, this will include children receiving CSoC services and EBPs.	BH utilization reports P/P BHUM Outcome measures and evidence that was shared with LDH	Full			
14.1.21.1 14.1.21.2	.1 For members for whom outcomes are assessed, the MCO shall report on the number and percentage of members who show improved functioning with treatment, as well as the amount of improvement. .2 In addition, the MCO shall develop a strategy to increase the use of outcome measurements for all members receiving specialized behavioral health services; the strategy will be due to LDH-OBH on an annual base.	Outcome measures and results BH outcome measures and evidence shared with LDH	Full			
14.2						
14.2.1	The MCO shall form a QAPI Committee that shall, at a minimum include:					
14.2.1.1	**QAPI Committee Members** The MCO Medical Director must serve as either the chairman or co-chairman;	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.2	The MCO Behavioral Health Director;	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.3	Appropriate MCO staff representing the	QAPI Program	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	various departments of the organization will have membership on the committee;	Description Composition of QAPI Committee				
14.2.1.4	The MCO is encouraged to include a member advocate representative on the QAPI Committee; and	QAPI Program Description Composition of QAPI Committee	Full			
14.2.1.5	The MCO shall include LDH representative(s) on the QAPI Committee, as designated by LDH as non-voting member(s).	QAPI Program Description Composition of QAPI Committee	Full			
14.2.2	**QAPI Committee Responsibilities** The committee shall meet on a quarterly basis. Its responsibilities shall include:	QAPI Program Description QAPI Work Plan QAPI Committee Description including roles and responsibilities	Full			
14.2.2.1	Direct and review quality improvement (QI) activities;	QAPI Program Description	Full			
14.2.2.2	Assure than QAPI activities take place throughout the MCO;	QAPI Program Description	Full			
14.2.2.3	Review and suggest new and or improved QI activities;	QAPI Program Description	Full			
14.2.2.4	Direct task forces/committees to review areas of concern in the provision of healthcare services to members;	QAPI Program Description	Full			
14.2.2.5	Designate evaluation and study design procedures;	QAPI Program Description	Full			
14.2.2.6	Conduct individual PCP and LMHP and practice quality performance measure profiling;	QAPI Program Description	Full			
14.2.2.7	Report findings to appropriate executive authority, staff, and departments within the MCO;	QAPI Program Description	Full			
14.2.2.8	Direct and analyze periodic reviews of members' service utilization patterns;	QAPI Program Description	Full			
14.2.2.9	Maintain minutes of all committee and sub-	QAPI Program	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	committee meetings and submit meeting minutes to LDH;	Description				
14.2.2.10	Report an evaluation of the impact and effectiveness of the QAPI program to LDH annually. This report shall include, but is not limited to, all care management services;	QAPI Program Description	Full			
14.2.2.11	Ensure that the QAPI committee chair attends LDH quality meetings; and	QAPI Program Description	Full			
14.2.2.12	Update provider manuals and other relevant clinical content on a periodic basis as determined by the committee chairperson.	QAPI Program Description	Full			
14.2.3	**QAPI Work Plan** The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction provided by the governing body. The QAPI plan shall be submitted to LDH within thirty (30) days after the effective date of the contract and annually thereafter, and prior to implementation of revisions. The QAPI plan, at a minimum, shall:	QAPI Program Description QAPI Work Plan Evidence of timely submission of the written QAPI plan	Full			
14.2.3.1	Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;	QAPI Program Description	Full			
14.2.3.2	Include processes to evaluate the impact and effectiveness of the QAPI Program;	QAPI Program Description	Full			
14.2.3.3	Include a description of the MCO staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities;	QAPI Program Description	Full			
14.2.3.4	Describe the role of its providers in giving input to the QAPI Program; and	QAPI Program Description	Full			
14.2.3.5	Be exclusive to Louisiana Medicaid and shall not contain documentation from other state Medicaid programs or product lines operated by the MCO.	QAPI Program Description	Full			
14.2.3.6	Describe the methods for ensuring data	QAPI program	Substantial	Full	This requirement is addressed in	

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	collected and reported to LDH is valid, accurate, and reflects providers' adherence to clinical practice guidelines as appropriate.	description	This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11 regarding data collection, and in the HEDIS Administration Process Policy and Procedure regarding HEDIS measures, as well as reliability for manual chart abstraction; however, the methods the plan uses to ensure data validity and reliability for Intervention Tracking Measures used for PDSA QI are not described. In response to EQRO request for documentation, the MCO submitted the 17-P Involan summary screen shot, which shows the logic for the retrospective annual 17-P measure but not for the concurrent monthly ITMs used to monitor CM outreach, engagement, and facilitation. On-site, the plan explained how the CM data used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **<u>Recommendation:</u>** The MCO should continue with their plan to improve		the IS Standard Tool, the HEDIS Administration Process Policy, and page 5 of the Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy.	

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			data integrity. MCO Response: Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.			
14.2.3.7	Include a fidelity monitoring plan which at a minimum includes the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.	Monitoring plan	Full			
14.2.4 14.2.4.1	**QAPI Reporting Requirements** The MCO shall submit QAPI reports annually to LDH which, at a minimum, shall include: • Quality improvement (QI) activities; • Recommended new and/or improved QI activities; and • Results of the evaluation of the impact and effectiveness of the QAPI program.	QAPI Program Description	Full			
14.2.4.3	The MCO shall provide data reports, including but not limited to ad-hoc reports and reports	QAPI Program Description	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	for special populations (e.g., DCFS/OJJ, nursing home populations), to LDH using the specifications and format approved by LDH. The MCO shall submit the reports based on the agreed upon dates established by the MCO and LDH.					
14.2.5 14.2.5.1	**Performance Measures** The MCO shall report on performance measures listed in Attachment E and in accordance with the timeline and format specified in the MCO Quality Companion Guide.	HEDIS IDSS results PM results	Full			
14.2.5.2	The MCO shall have processes in place to monitor and self-report all performance measures.	P/P performance measures Final audit report	Full			
14.2.5.3	The data shall demonstrate adherence to clinical practice guidelines and improvement in patient outcomes.	P/P performance measurement	Full			
14.2.5.4	The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	P/P QAPI program description	Full			
14.2.5.5	The tools and reports shall be flexible and adaptable to changes in the quality measurements required by LDH.	P/P QAPI program description	Full			
14.2.5.6	The MCO shall maintain integrity, accuracy, and consistency in data reported. Upon request, the MCO shall submit to LDH detail sufficient to independently validate the data reported.	QAPI Program Description QAPI Work Plan	Substantial This requirement is addressed in the 2019 QM Program Description Appendices A to F on pages 10-11, and the 17-P Inovalon summary screen shot presents the logic for the annual 17P performance measure, which is also supported by the HEDIS Administration Process policy on page 7;	Full	This requirement is addressed in the IS Standard Tool, the HEDIS Administration Process Policy, and page 5 of the Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy.	

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			however, pertinent to contractual requirement 14.2.5.2, the similarity between the monthly ITM denominator to measure pregnant women with a prior preterm birth and the annual 17P denominator merits supporting documentation and explanation of the accuracy of these measures. On-site, the plan explained how the CM data used for outreach were accurate and how moving forward with ITM data, this issue was addressed. **Recommendation:** The MCO should continue with their plan to improve data integrity. MCO Response: Healthy Blue will continue to follow our policies and procedures related to data integrity and is committed to ensuring that data accuracy is number one priority. We will ensure that all data submitted is reviewed through an IRR process. **Final Review Determination**:			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			No change in determination. The plan agreed to the recommendation moving forward.			
14.2.5.7 14.2.5.7.1	**Incentive Based Performance Measures** Incentive Based (IB) measures are measures that may affect PMPM payments and can be identified in Attachment E annotated with "$$".	HEDIS results – incentive measures	Full			
14.2.5.7.2	Based on an MCO's Performance Measure outcomes for CYE 12/31/2015, a maximum of $22,25000,000 ($250,000 per measure) in October following the measurement CY will be withheld from payment if specified performance measures fall below LDH's established benchmarks for improvement.					
14.2.5.7.3	LDH expressly reserves the right to modify existing performance IB measures. Any changes in the Incentive Based performance measures will require an amendment to the Contract and LDH will provide six (6) months' notice of such change.	P/P Performance measures	Not applicable.			
14.2.5.8 14.2.5.8.1	**Performance Measures Reporting** The MCO shall utilize systems, operations, and performance monitoring tools and/or automated methods for monitoring.	HEDIS results IDSS submission Final audit report				
14.2.5.8.2	The tools and reports will be flexible and adaptable to changes in the quality measurements required by LDH.		Full			
14.2.5.8.3	The MCO shall have processes in place to monitor and self-report performance measures as specified in Section 14.2.5 Performance Measures.	P/P performance measures	Full			
14.2.5.9	Beginning in 2018, the MCO shall submit audited HEDIS results to NCQA according to NCQA's HEDIS data submission timeline for	P/P performance measures	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	health plans to submit final Medicaid HEDIS results (typically June 15 of each calendar year).					
14.2.8 14.2.8.1	**Performance Improvement Projects** The MCO shall establish and implement an ongoing program of Performance Improvement Projects (PIP) that focuses on clinical and non- clinical performance measures as specified in 42 CFR §438.330.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.2	The MCO shall perform two (2) LDH-approved PIPs listed in Appendix DD – Performance Improvement Projects for the initial three-year term of the contract. LDH may require up to two (2) additional projects for a maximum of four (4) projects.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.2.1	Effective 2/1/16, the MCO shall perform a minimum of one (1) additional LDH-approved behavioral-health PIP each contract year.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.3	Performance Improvement Projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time, with favorable effects on health outcomes and enrollee satisfaction. Each project must involve the following: • Measurement of performance using objective quality indicators; • Implementation of interventions to achieve improvement in the access to and quality of care; • Evaluation of the effectiveness of the interventions; and • Planning and initiation of activities for increasing or sustaining improvement.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.2.8.4	Within three (3) months of the execution of the Contract and at the beginning of each Contract year thereafter, the MCO shall submit, in writing, a general and a detailed description of each Performance Improvement Project to LDH for approval. The detailed description shall include: • An overview explaining how and why the project was selected, the status of the PIP, and its relevance to the MCO members and providers; • The study question; • The study population; • The quantifiable measures to be used, including the baseline and goal for improvement; • Baseline methodology; • Data sources; • Data collection methodology and plan; • Data collection plan and cycle, which must be at least monthly; • Results with quantifiable measures; • Analysis with time period and the measures covered; • Explanation of the methods to identify opportunities for improvement; and • An explanation of the initial interventions to be taken.	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			
14.2.8.5	PIPs used to measure performance improvement shall include diagrams (e.g. algorithms and/or flow charts) for monitoring and shall: • Target specific conditions and specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation; • Use clinical care standards and/or practice	PIP proposal/reports P/P performance input projects PIP meeting minutes	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	guidelines to objectively evaluate the care the MCO delivers or fails to deliver for the targeted clinical conditions; • Use appropriate quality indicators derived from the clinical care standards and/or practice guidelines to screen and monitor care and services delivered; • Implement system interventions to achieve improvement in quality, including a (PDSA) cycle; • Evaluate the effectiveness of the interventions; • Provide sufficient information to plan and initiate activities for increasing or sustaining improvement; • Monitor the quality and appropriateness of care furnished to enrollees with special health care needs; • Reflect the population served in terms of age groups, disease categories, and special risk status, • Ensure that multi-disciplinary teams will address system issues; • Include objectives and quantifiable measures based on current scientific knowledge and clinical experience and have an established goal benchmark; • Validate the design to assure that the data to be abstracted during the QI project is accurate, reliable and developed according to generally accepted principles of scientific research and statistical analysis, and • Maintain a system for tracking issues over time to ensure that actions for improvement are effective.					
14.2.10 14.2.10.1	**Member Satisfaction Surveys** The MCO shall conduct annual Consumer Assessment of Healthcare Providers and	CAHPS report	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members.					
14.2.10.2 14.2.10.3	The MCO shall enter into an agreement with a vendor that is certified by NCQA to perform CAHPS surveys. The MCO's vendor shall perform CAHPS Adult surveys; and CAHPS Child surveys, including the Children with Chronic Conditions survey supplement.	CAHPS Vendor contract	Full			
14.2.10.4	Survey results and a description of the survey process shall be reported to LDH separately for each required CAHPS survey. CAHPS survey results are due with all other performance measures.	CAHPS report	Full			
14.2.10.5	The CAHPS survey results shall be reported to LDH or its designee for each survey question. These results may be used by LDH for public reporting. Responses will be aggregated by LDH or its designee for reporting. The survey shall be administered to a statistically valid random sample of clients who are enrolled in the MCO at the time of the survey.	CAHPS data file	Full			
14.2.10.6	The surveys shall provide valid and reliable data for results.	Evidence CAHPS vendor was used	Full			
14.2.10.7	Analyses shall provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.	CAHPS reports	Full			
14.2.10.8 14.2.10.8.1 14.2.10.8.2 14.2.10.8.3 14.2.10.8.4 14.2.10.8.5	The most current CAHPS Health Plan Survey (currently 5.0) for Medicaid Enrollees shall be used and include: .1 Getting Needed Care, .2 Getting Care Quickly, .3 How Well Doctors Communicate, .4 Health Plan Customer Service, .5 Global Ratings.	CAHPS reports	Full			
14.2.10.9	The MCO's vendor shall perform a LDH-approved behavioral health survey to be	P/P Behavioral health survey	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	standardized across the MCOs. The survey results shall be reported to LDH on an annual basis.	Timeline for BH survey administration BH survey results, if administered				
14.4						
14.4.1	The MCO must attain health plan accreditation by NCQA. If the MCO is not currently accredited by NCQA, the MCO must attain accreditation by meeting NCQA accreditation standards.	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.2	The MCO's application for accreditation must be submitted at the earliest point allowed by the organization. The MCO must provide LDH with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements.	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3	The MCO shall provide LDH with a copy of its most recent accreditation review including:	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.1	Accreditation status, survey type, and level (as applicable);	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.2	Accreditation results, including recommended actions or improvements, corrective action plan, and summaries of findings; and	Accreditation Status including copy of accreditation report if accredited	Full			
14.4.3.3	Expiration date of the accreditation.	Accreditation Status including copy of	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
		accreditation report if accredited				
14.4.4	Achievement of provisional accreditation status shall require a CAP within thirty (30) calendar days of receipt of the Final Report from NCQA. Failure to obtain full NCQA accreditation and to maintain the accreditation thereafter shall be considered a breach of the Contract and shall result in termination of the Contract.	Accreditation Status including copy of accreditation report if accredited	Not applicable			
14.5						
14.5.1	The MCO shall establish a Member Advisory Council to promote collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs.	Member Advisory Council Plan Member Advisory Council Composition Member Advisory Council Description including roles and responsibilities	Full			
14.5.2	The Council is to be chaired by the MCO's Administrator/CEO/COO or designee and will meet at least quarterly.	Member Advisory Council Plan Composition of Member Advisory Council	Full			
14.5.3	Every effort shall be made to include a broad representation of both members/families/significant others, member advocacy groups and providers that reflect the population and community served. At least one family member/caregiver of a child with special health care needs shall have representation on the committee. Members/families/significant others and member advocacy groups shall make up at least fifty per cent (50%) of the membership.	Member Advisory Council Plan Member Advisory Council Composition	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
14.5.4.	The MCO shall provide an orientation and ongoing training for Council members so they have sufficient information and understanding to fulfill their responsibilities.	Member Advisory Council Plan	Full			
14.5.5.	The MCO shall develop and implement a Member Advisory Council Plan that outlines the schedule of meetings and the draft goals for the council that includes, but is not limited to, member's perspectives to improve quality of care. This plan shall be submitted to LDH within thirty (30) days of signing the Contract and annually thereafter.	Member Advisory Council Plan Evidence of timely submission of a Member Advisory Council Plan	Full			
14.5.6.	LDH shall be included in all correspondence to the Council, including agenda and Council minutes. Additionally, all agenda and Council minutes shall be posted to the MCO website in English and Spanish, with any member-identifying information redacted.	Member Advisory Council Plan	Full			
14.6 14.6.1	**Fidelity to Evidence-Based Practices** The MCO will establish a fidelity-monitoring plan in place for Evidenced Based Practice providers to ensure providers' adherence to evidence-based and evidence-informed practices to ensure the core elements of the intervention are maintained and minimum fidelity standards are met. The providers maintain fidelity monitoring for Functional Family Therapy (FFT), Multisystemic Therapy (MST), and Homebuilders and Assertive Community Treatment Act (ACT) as part of the certification/credentialing process. The MCO will maintain Memorandums of Understanding (MOUs) with the fidelity monitoring agencies for Family Functional Therapy, Multisystemic Therapy, and Homebuilders. The MOUs outline a collaborative protocol between the MCO and the monitoring agencies to ensure the	Fidelity monitoring plan MOUs Evidence of submission to LDH	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	appropriate exchange of fidelity reports and other quality reports.					
14.6.2	The MCO will manage the fidelity monitoring process for Assertive Community Treatment (ACT) providers to ensure minimum fidelity standards utilizing the LDH specified ACT Monitoring tool. The MCO shall ensure their staff are properly trained on utilization of the identified ACT Monitoring tool.	Fidelity monitoring plan Evidence of submission to LDH	Full			
14.6.3	A formal fidelity-monitoring plan will be submitted to the State within 30 days of the beginning of the contract, which includes at a minimum the fidelity criteria for each applicable service/provider type, sampling approach, data collection methods, tools to be used, frequency of review, and validation methods. The monitoring system shall include a formalized monitoring review process of all providers' performance on an ongoing basis including a procedure for formal review with site-visits. Site visits shall be conducted according to a periodic schedule individualized by provider type determined by the MCO and approved by LDH. Reports will be submitted to LDH according to the frequency established in the fidelity monitoring plan submitted to the State, but no less than once per year.	Fidelity monitoring plan Site visit reports Evidence of submission to LDH	Full			
14.8 14.8.1	**Adverse Incident Reporting** The MCO shall develop, submit, and implement a critical reporting and management procedures for the behavioral health population, subject to review and approval by LDH. The procedure shall describe how the MCO will detect, report, remediate (when applicable), and work to prevent the future re-occurrence of incidents.	P/P BH reporting Critical incident reporting system	Full			
14.8.2	The MCO, as directed by LDH, may be required					

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	to utilize a third party incident management system in lieu of, or in addition to, its own incident management reporting system. Connection to this third party system is at the cost of the MCO. It shall be the MCO's decision to replace its own incident management system with the requested third party system or to utilize both systems for incident management.					
14.8.3	The MCO shall submit reports to LDH concerning quality of care concerns and adverse incidents, as documented in the Behavioral Health Companion Guide.	P/P BH reporting	Full			
14.9						
14.9.1	The MCO shall develop and implement a plan for monitoring specialized behavioral health providers and facilities across all levels of care, which incorporates onsite reviews and member interviews. The MCO shall submit the plan to LDH for approval within 30 calendar days of contract execution and at least 60 days prior to revision. The MCO's plan shall comply with all the requirements as specified by LDH:	P/P BH reporting Evidence of report submission to LDH	Full			
14.9.1.1	Review criteria for each applicable provider type/level of care;		Full			
14.9.1.2	Sampling approach including number and percent of onsite audits by provider type, number and percent of desktop audits, and number of charts to be reviewed at each provider location;		Full			
14.9.1.3	Member interview criteria;		Full			
14.9.1.4	Random audit selection criteria;		Full			
14.9.1.5	Tools to be used;		Full			
14.9.1.6	Frequency of review, including schedule of reviews by provider type;		Full			
14.9.1.7	Corrective actions to be imposed based on the degree of provider non-compliance with		Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	review criteria elements on both an individual and systemic basis;					
14.9.1.8	Plan for ensuring corrective actions are implemented appropriately and timely by providers; and		Full			
14.9.1.9	Inter-rater reliability testing methods.		Full			
14.9.2	At a minimum, the MCO's sampling approach shall result in a statistically significant representative sample with a confidence interval of 95% + or - 5 for each level of care. The sample shall be random and include providers who have served at least one member during the review period. Levels of care include mental health outpatient, substance use outpatient, and inpatient /residential. Additional levels of care may be added at the discretion of LDH.	P/P BH reporting	Full			
14.9.3	The MCO's review criteria shall address the following areas at a minimum:	P/P BH reporting	Full			
14.9.3.1	Adherence to clinical practice guidelines;		Full			
14.9.3.2	Member rights and confidentiality, including advance directives and informed consent;		Full			
14.9.3.3	Cultural competency;		Full			
14.9.3.4	Patient safety;		Full			
14.9.3.5	Compliance with adverse incident reporting requirements;		Full			
14.9.3.6	Appropriate use of restraints and seclusion, if applicable;		Full			
14.9.3.7	Treatment Planning components, including criteria to determine: the sufficiency of assessments in the development of functional treatment recommendations; the treatment plan is individualized and appropriate for the enrollee and includes goals, Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) objectives, and the appropriate service to achieve goal/objective;		Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	individualized crisis plan; members'/families' cultural preferences are assessed and included in the development of treatment plans; the treatment plan has been reviewed regularly and updated as the needs of the member changes; the treatment plan includes the involvement of family and other support systems in establishing treatment goals/objectives; the treatment plan includes evidence of implementation as reflected in progress notes; and evidence that the member is either making progress toward meeting goals/objectives or there is evidence the treatment has been revised/updated to meet the changing needs of the member; and					
14.9.3.8	Continuity and coordination of care, including adequate discharge planning		Full			
14.9.4	The MCO shall take steps to require adoption of clinical practice guidelines by specialized behavioral health providers and measure compliance with the guidelines until such point that 90% or more of providers consistently achieve at least 80% compliance based on MCO measurement findings.					
14.9.5	The MCO shall ensure that an appropriate corrective action is taken when a provider furnishes inappropriate or substandard services as determined by the MCO, when a provider does not furnish a service that should have been furnished, or when a provider is out of compliance with federal and state regulations. The MCO shall monitor and evaluate corrective actions taken to ensure that appropriate changes have been made in a timely manner.	Provider Monitoring P/P	Full			
14.9.6	The MCO shall submit quarterly reports which summarize monitoring activities, findings,	Provider Monitoring P/P	Full			

Quality Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.240)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	corrective actions, and improvements for Specialized Behavioral Health Services.	Provider Monitoring Reports				
14.10						
14.10.1	The MCO shall assess the treatment progress and effectiveness of Specialized Behavioral Health Services for both children and adults using standardized clinical outcome tools and measures, according to the guidelines specified by LDH.	BH outcome assessment plan Assessment Reports	Full			
14.10.2	The MCO shall ensure providers and appropriate MCO staff are adequately trained/ certified in the use of such tools and such training/certification is current.	BH outcome assessment plan Training materials Evidence of Training Attendance	Full			
14.10.3	The MCO shall be responsible for data collection of outcome data, data validation activities, and reporting to the LDH.	BH outcome assessment plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
15.1	**General Requirements**					
15.1.1	The MCO and its subcontractors shall comply with all state and federal laws and regulations relating to fraud, abuse and waste in the Medicaid and CHIP programs, including but not limited to 42 CFR 438.1-438.812 and La.R.S. 46:437.1-437.14; LAC 50:1.4101-4235 and Sections 1128, 1156, and 1902(a)(68) of the Social Security Act..					
15.1.2	The MCO's Program Integrity Officer and CEO or COO shall meet with LDH and the state's Office of Attorney General Medicaid Fraud Control Unit (MFCU) quarterly, annually, and at LDH's request, to discuss fraud, abuse, waste, neglect and overpayment issues. For purposes of this Section, the MCO's Program Integrity Officer shall serve as the primary point of contact for the MCO on issues related to Fraud, Abuse, and Waste Prevention.					
15.1.3	The MCO and its subcontractors shall cooperate and assist the state and any state or federal agency charged with the duty of identifying, investigating, or prosecuting suspected fraud, abuse or waste. At any time during normal business hours, CMS, the Office of the Inspector General (OIG), HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, LDH, and/or any of the designees of the above, and as often as they may deem necessary during the Contract period and for a period of ten (10) years from the expiration date of the Contract (including any extensions to the Contract), or from the date of completion of any audit, whichever is later, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the Contract and any other applicable rules. MFCU shall be allowed	FWA Compliance Plan	Substantial This requirement is partially addressed within the March 2019 SIU Antifraud Plan. Missing from the language is the requirement addressing that regulatory agencies may have access to information regarding the quality, timeliness and appropriateness of services 10 years from the expiration of the Contract or from the date of any audit completion, whichever is later. Also missing from the language is that under special circumstances, MFCU will be allowed after-hours admission. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit	Full	This requirement is addressed within the SIU Antifraud Plan on pages 58-59. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	access to the place of business and to all Medicaid records of any contractor, subcontractor, or provider during normal business hours, except under special circumstances determined by the MFCU when after-hour admission will be allowed.		review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.1.4	The MCO and its subcontractors shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, LDH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract.	FWA Compliance Plan	Full			
15.1.5	The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained.					
15.1.6	The MCO and its providers and subcontractors shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	FWA Compliance Plan	Substantial This requirement is partially addressed by the March 2019 SIU Antifraud Plan on page 28. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. **MCO Response:** Language has been added to the Anti-Fraud	Full	This requirement is addressed within the SIU Antifraud Plan on page 59. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Plan and is currently in review with LDH.			
15.1.7	MCO's employees consultants, and its subcontractors and their employees shall cooperate fully and be available in person for interviews and consultation regarding grand jury proceedings, pre-trial conferences, hearings, trials, and in any other process.	FWA Compliance Plan	Full			
15.1.8	The MCO and its subcontractors shall provide access to LDH and/or its designee to all information related to grievances and appeals files by its members. LDH shall monitor enrollment and termination practices and ensure proper implementation of the MCO's grievance procedures, in compliance with 42 CFR §438.226-228.	FWA Compliance Plan	Substantial This requirement language is missing in the March 2019 SIU Antifraud Plan on page 26. However, LDH approval of any grievance procedures prior to implementation is discussed in the Member Complaints and Grievances document. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language. **MCO Response:** Requirement will be added to the Anti-Fraud Plan.	Full	This requirement is addressed within the SIU Antifraud Plan on page 59. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.9	The MCO shall certify all statements, reports and claims, financial and otherwise, as true, accurate, and complete. The MCO shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, the Contract, and LDH policy.	FWA Compliance Plan	Substantial The language is missing from the March 2019 SIU Antifraud plan. On pages 7 and 8 of the Program Integrity plan, cost avoidance integration with claims adjudication and cost containment activities are discussed. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Full	This requirement is addressed within the SIU Antifraud Plan on page 59. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.1.10	The MCO will report to LDH, within three (3) business days, when it is discovered that any MCO employee(s), network provider, subcontractor, or subcontractor's employee(s) have been excluded, suspended, or debarred from any state or federal healthcare benefit program via the designated LDH Program Integrity contact.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms	Minimal This requirement is not addressed in the March 2019 SIU Antifraud Plan. As discussed onsite, the MCO does ongoing monitoring of their provider network, employees and subcontractors. The MCO provided an Excluded Individuals and Entities policy. However, language concerning sending reports to LDH within a three day timeframe is missing in the provided documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language. MCO Response: Language will be added to Anti-Fraud Plan.	Full	This requirement is addressed within the SIU Antifraud Plan on page 59. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.11	The MCO and its subcontractors shall have surveillance and utilization control programs and procedures pursuant to (42 CFR §438.608(a)(1)) to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments. The MCO shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud, waste, and abuse activities.	FWA Compliance Plan	Full			
15.1.12	The MCO, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR §455.104 and 42 CFR §438.610) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall submit routine	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms	Minimal The requirement is evidenced by the Provider Disclosure Form but the language is missing in the March 2019 SIU Antifraud Plan. As discussed onsite, disclosures are a part of the ongoing activities and credentialing processes overseen by the provider network.	Full	This requirement is addressed within the SIU Antifraud Plan on page 51. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request.		Disclosures are referenced in the provider agreement in section 6.23, but timeliness of routinely submitted disclosures is not addressed in any documentation. **Recommendation** The MCO should update the SIU Antifraud Plan, which is in review with LDH, to include this requirement language. MCO Response: Medicaid Subcontractors Disclosure of Ownership P&P – Full Document. Credentialing Policies are to be revised to reflect all applicable timeframes. **Final Review Determination** No change in determination. Although the Medicaid Subcontractors Disclosure of Ownership documentation does satisfy the requirement and would be substantial evidence the MCO has policies in place that address this requirement, the document was not provided for the pre-onsite review or the onsite follow-up documentation. Please provide this document to show compliance with the requirement for the next audit review period and please include language on the timeframes where applicable.			
15.1.13	The MCO, as well as its subcontractors and providers, shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms Employee Disclosure Forms	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or the MCO dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.					
15.1.14	The MCO shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the MCO in preventing and detecting potential fraud, waste, and abuse. At a minimum the MCO shall have one (1) full-time investigator physically located within Louisiana for every 50,000 members or fraction thereof. This full-time position(s) is/are in addition to the Program Integrity Officer and must be located in-state. LDH may approve written requests with detailed justification to substitute another SIU position in place of an investigator position.	FWA Compliance Plan	Full			
15.1.15	LDH or its designee will notify the MCO when it is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to a provider when the issues, services or claims upon which the recoupment or withhold are based meet one or more of the following criteria:	FWA Compliance Plan	Minimal This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite. Language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. The MCO did confirm onsite that LDH approval is needed in order for recoupments or withholds to occur. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u>	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.1.15.1	The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or	FWA Compliance Plan	Minimal This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan	Minimal This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Plan and is currently in review with LDH.			
15.1.15.3	When the issues, services or claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC.	FWA Compliance Plan	Minimal This requirement is not addressed by the Program Integrity Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.16	The prohibition described above in Section 15.1.15 shall be limited to a specific provider(s), for specific dates, and for specific issues, services or claims. In the event that the MCO obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, the MCO will return the funds to LDH.	FWA Compliance Plan	Minimal This requirement is not addressed by the Program Integrity Plan nor the March 2019 SIU Antifraud Plan. Payment recovery and SIU activities were discussed with staff onsite, however language on MCO prohibited actions to recoup funds is not addressed in the March 2019 SIU Antifraud Plan. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Plan and is currently in review with LDH.			
15.1.17	The MCO shall confer with LDH before initiating any recoupment or withhold of any program integrity-related funds as defined in 15.1.15 (see 15. 7 for audit coordination procedure) to ensure that the recovery, recoupment, or withhold is permissible..	FWA Compliance Plan Payment Suspension P/P	Minimal The language is missing from the March 2019 SIU Antifraud plan and is not addressed in the Program Integrity Plan. This requirement is minimally addressed by the Overpayments Policy. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 60. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.18	**Reporting and Investigating Suspected Fraud and Abuse**					
15.1.18.1	The MCO and its subcontractors shall cooperate with all appropriate state and federal agencies, including MFCU, in investigating fraud and abuse.					
15.1.18.2	The MCO shall have methods for identification, investigation, and referral of suspected fraud cases (42 CFR §455.13, §455.14, §455.21) both internally and for its subcontractors.	FWA Compliance Plan	Full			
15.1.18.3	The MCO shall notify MFCU and LDH simultaneously and in a timely manner regarding all internal (such as identified patterns of data mining outliers, audit concerns, critical incidences) and external (such as hotline calls) tips with potential implications to Louisiana Medicaid providers' billing anomalies and/or to safety of Medicaid enrollees that results in a full investigation (42 CFR §455.15). Along with a notification, the MCO shall take steps to triage and/or substantiate these tips and provide	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	simultaneous and timely updates to MFCU and LDH when the concerns and/or allegations of any tips are authenticated.					
15.1.18.4	The MCO shall report all tips, confirmed or suspected fraud, waste and abuse to LDH and the appropriate agency as follows:	FWA Compliance Plan	Full			
15.1.18.4.1	All tips (regarding any potential billing or claims issue identified through either complaints or internal review received within the previous month) shall be reported to LDH Program Integrity monthly; LDH	FWA Compliance Plan Evidence of report submission	Full			
15.1.18.4.2	Suspected fraud and abuse in the administration of the program shall be reported to LDH Program Integrity and MFCU;	FWA Compliance Plan	Full			
15.1.18.4.3	All confirmed or suspected provider fraud and abuse shall immediately be reported to LDH Program Integrity and MFCU; and	FWA Compliance Plan	Full			
15.1.18.4.4	All confirmed or suspected enrollee fraud and abuse shall be reported immediately, in writing, to LDH Program Integrity and local law enforcement of the enrollee's parish of residence..	FWA Compliance Plan	Substantial The language of the contract is not addressed in the March 2019 SIU Antifraud Plan but staff was able to speak to the investigative process onsite. Provider and Member Fraud Referral Forms were provided. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.18.5	When making a referral of suspected fraud, the MCO shall utilize a Fraud Reporting Form deemed satisfactory by LDH under the terms of this	FWA Compliance Plan Provider referral forms	Substantial The language of the contract is not addressed in the March 2019 SIU Antifraud Plan. MCO	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Contract. The MCO shall report suspected provider fraud using the LDH Provider Fraud Referral Form		provided a Fraud Referral Template and a Fraud Notice Template that shows compliance with the requirement. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.		from LDH noted that the plan was approved.	
15.1.18.6	The MCO shall be subject to a civil penalty, to be imposed by the LDH, for willful failure to report fraud and abuse by employees, subcontractors, beneficiaries, recipients, enrollees, applicants, or providers to LDH MFCU, as appropriate.					
15.1.18.7	The MCO shall promptly perform a preliminary investigation of all incidents of suspected and/or confirmed fraud and abuse. Unless prior written approval is obtained from the agency to whom the incident was reported, or to another agency designated by the agency that received the report, after reporting fraud or suspected fraud and/or suspected abuse and/or confirmed abuse, the MCO shall not take any of the following actions as they specifically relate to Medicaid claims:	FWA Compliance Plan	Substantial The language of the contract is partially addressed in the SIU Antifraud Plan and is partially addressed by the Investigations of Suspected Fraud and Abuse policy document. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan	Minimal This requirement language, although	Full	This requirement is addressed within the SIU Antifraud Plan on	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			referenced, is missing in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes. Recommendation The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.		page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan	Substantial This requirement language is partially addressed on page 25 in the SIU Antifraud Plan. SIU staff onsite were able to speak to their investigative processes. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.18.7.3	Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident.	FWA Compliance Plan	Minimal This requirement language is not listed in the SIU Antifraud Plan, however, SIU staff onsite were able to speak to their investigative processes. **Recommendation**	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.1.18.8	The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident was reported, or to another agency designated by the agency that received the report.	FWA Compliance Plan	Full			
15.1.18.9	The MCO and its subcontractors shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.	FWA Compliance Plan	Substantial The language is missing in the March 2019 SIU Antifraud Plan. MCO regularly meets with contracted vendors, and if vendors open a case, they notify the MCO so they can inform the state and a case is opened with the reporting vendor. Discussed onsite, the Dental vendor does their own investigations. The MCO has the ability to make referrals to vendors and has the ability to mine their vendor's data. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response:	Full	This requirement is addressed within the SIU Antifraud Plan on page 61. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.1.18.10	The MCO and/or its subcontractors are to suspend payment to a network provider when the state determines there is a credible allegation of fraud, unless the state determines there is good cause for not suspending payments to the network provider pending the investigation. The MCO is responsible for sending the network provider the required notice and appeal rights as required by the code of federal regulation.		Substantial This requirement was discussed onsite. The MCO does not actively suspend payments to providers unless directed by the state. The Provider Garnishment Process does not meet compliance for this requirement as it pertains to Kentucky requirements. **Recommendation** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. MCO Response: Overpayments Policy – Full Document Provider Hold Process – Full Document Payment suspension policy is being created specific to LA **Final Review Determination** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana should be developed.	Full	This requirement is addressed within the SIU Antifraud Plan on page 52. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.1.19	The State shall not transfer its law enforcement functions to the MCO.					
15.1.20	The MCO and/or subcontractors shall include in any	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of its provider agreements a provision requiring, as a condition of receiving any amount of Medicaid payment, that the provider comply with this Section, Section 15 of this Contract.	Provider Agreement Form				
15.1.21	The MCO shall notify LDH when the MCO or its subcontractor denies a provider credentialing application or disenrolls a provider for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.	FWA Compliance Plan Provider Enrollment, Disclosure & Credentialing Forms	Full			
15.1.22	The MCO shall report overpayments made by LDH to the MCO within 60 calendar days from the date the overpayment was identified.	FWA Compliance Plan	Full			
15.1.23	Unless prior written approval is obtained from LDH, the MCO shall not employ extrapolation methods to derive an overpayment in a provider audit..	FWA Compliance Plan	Full			
15.2	**Fraud and Abuse Compliance Program**					
15.2.1	In accordance with 42 CFR §438.608(a), the MCO and its subcontractors, to the extent that the subcontractor is delegated responsibility by the MCO for coverage of services and payment of claims under the contract between the MCO and the state, shall have a compliance program that includes administrative and management arrangements or procedures, including a mandatory Fraud and Abuse Compliance Plan designed to prevent, reduce, detect, correct, and report known or suspected fraud, abuse, and waste in the administration and delivery of services.	FWA Compliance Plan	Full			
15.2.2	In accordance with 42 CFR §438.608 (a)(1)(ii), the MCO's compliance program shall designate a contract compliance officer who is responsible for developing and implementing written policies, procedures, and standards to ensure compliance with the requirements of this contract and all applicable Federal and State requirements, and who reports directly to the CEO and board of	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	directors. .					
15.2.3	The MCO shall have an adequately staffed Medicaid Program Integrity office with oversight by the Program Integrity Officer	FWA Compliance Plan PI Org chart and resumes	Full			
15.2.4	The MCO shall establish and implement procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, promptly respond to compliance issues as they are raised, investigate potential compliance problems as identified in the course of self-evaluation and audits, correct such problems promptly and thoroughly, including coordinating with law enforcement agencies if issues are suspected to be criminal in nature, to reduce the potential for recurrence, and conduct ongoing compliance with the requirements under the contract.	FWA Compliance Plan	Full			
15.2.6	In accordance with 42 CFR 438.608(a)(1)(iii), the compliance program shall establish a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with oversight of the compliance program and its compliance with the requirements under this contract.	FWA Compliance Plan Compliance Committee Charter Compliance Committee meeting minutes	Full			
15.2.6	The MCO shall submit the Fraud and Abuse Compliance Plan within thirty (30) days from the date the Contract is signed. The MCO shall submit updates or modifications to LDH for approval at least thirty (30) days in advance of making them effective. LDH, at its sole discretion, may require that the MCO modify its compliance plan. The MCO compliance program shall incorporate the policy and procedures as follows:	FWA Compliance Plan	Full			
15.2.6.1	Written policies, procedures, and standards of conduct that articulate MCO's commitment to comply with all applicable federal and state standards;		Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
15.2.6.2	Effective lines of communication between the Contract Compliance Officer and the MCO's employees, providers and contractors		Full			
15.2.6.3	Enforcement through well-publicized disciplinary guidelines;		Full			
15.2.6.4	Procedures for ongoing monitoring and auditing of MCO systems, including, but not limited to, claims processing, billing and financial operations, enrollment functions, member services, continuous quality improvement activities, and provider activities;		Full			
15.2.6.5	Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Contract Compliance Officer, to receive them. Several independent reporting paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel;		Full			
15.2.6.6	Provisions for internal monitoring and auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);		Full			
15.2.6.7	Written policies and procedures for conducting both announced and unannounced site visits and field audits on providers to ensure services are rendered and billed correctly.		Full			
15.2.3.8	Protections to ensure that no individual who reports compliance plan violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the MCO. The MCO shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible. Anyone who believes that he or she has been retaliated against may report this violation to LDH and/or the U.S. Office of Inspector General.		Full			
15.2.6.9	Procedures for prompt notification to LDH when the MCO receives information about changes in a		Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.					
15.2.6.10	Procedures for prompt notification to LDH when the MCO receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the program.		Full			
15.2.6.11	Provisions for a prompt response to detected offenses and for development of corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);		Full			
15.2.6.12	Effective training and education system for the Contract Compliance Officer, program integrity investigators, managers, and members to ensure that they know and understand the federal and state standards and requirements of MCO's contract;		Full			
15.2.6.13	Fraud, Waste and Abuse Training shall include, but not be limited to: • Annual training of all employees; • New hire training within thirty (30) days of beginning date of employment.		Full			
15.2.6.14	The MCO will require new employees to complete and attest to training modules within thirty (30) days of hire related to the following in accordance with federal and state laws: • MCO Code of Conduct Training • Privacy and Security – Health Insurance Portability and Accountability Act • Fraud, waste, and abuse identification and reporting procedures • Federal False Claims Act and employee whistleblower protections • Procedures for timely consistent exchange of information and collaboration with LDH; • Organizational chart including the Program		Full			

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Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Integrity Officer and full-time program integrity investigator(s); and • Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by Department, HHS, CMS, and the Office of Inspector General, including updates and amendments to these documents or any such standards established or adopted by the state of Louisiana or its Departments.					
15.2.7	The MCO shall require and have procedures for a network provider to report to the MCO when it has received an overpayment, to return the overpayment to the MCO within sixty (60) calendar days of the date on which the overpayment was identified, and to notify the MCO in writing of the reason for the overpayment.	Overpayments Policy Overpayments notice form	Full			
	The MCO shall have procedures for prompt reporting to the State of all overpayments identified and recovered, specifying the overpayments due to potential fraud.	Overpayments Policy	Full			
15.3	**Prohibited Affiliations**					
15.3.1	In accordance with 42 CFR 438.610, the MCO and its subcontractors are prohibited from knowingly having a relationship with: An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.					
15.3.4	The MCO and its subcontractors shall comply with all applicable provisions of 42 CFR 438. 608 and 438.610 pertaining to debarment and/or	FWA Compliance Plan	Full			

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Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	suspension including written disclosure to LDH of any prohibited affiliation.. The MCO and its subcontractors shall screen all employees and contractors and network providers to determine whether they have been excluded from participation in Medicare. Medicaid, the Children's Health Insurance Program, and/or any federal health care programs. To help make this determination, the MCO shall conduct screening to comply with the requirements set forth at 42 CFR 455.436.					
15.3.5	The MCO shall search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE); • Louisiana Adverse Actions List Search; • The System of Award Management (SAM); and • Other applicable sites as may be determined by LDH	FWA Compliance Plan	Full			
15.3.6	The MCO and its subcontractors shall conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered should be reported to LDH within three (3) business days. Any individual or entity that employees or contracts with an excluded provider/individual cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded. For example, a pharmacy that fills a prescription written by an excluded provider for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR 1003.102(a)(2).					
15.3.6.1	An individual who is an affiliate of a prohibited person or entity described above include: • A director, officer, or partner of the MCO; • A subcontractor of the MCO; • A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or • A person with an employment, consulting or other arrangement with the MCO for the provision of items and services which are significant and material to the MCO's obligations under this contract. • A network provider.	FWA Compliance Plan	Full			
15.3.6.2	The MCO shall notify LDH in writing within three (3) days of the time it receives notice that action is being taken against the MCO or any person defined above or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO or a contractor from the Medicaid or CHIP program, or any program listed in Executive Order 12549.	FWA Compliance Plan	Full			
15.3.7	The MCO, through its Contract Compliance Officer, shall attest monthly to LDH that a search of the websites referenced in 15.3.5 been completed to capture all exclusions.	FWA Compliance Plan Copies of monthly reports	Full			
15.4	**Payments to Excluded Providers**					
15.4.1	Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or CHIP except for certain emergency services ; and	FWA Compliance Plan	Full			
15.4.2	The MCO is responsible for the return to the State	FWA Compliance Plan	Full			

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Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	of any money paid for services provided by an excluded provider.					
15.5	**Reporting**					
15.5.1	The MCO and its subcontractors shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect to the state's Office of Attorney General MFCU, and LDH within three (3) business days of discovery, taking prompt corrective actions and cooperating with LDH in its investigation of the matter(s).	FWA Compliance Plan	Minimal This requirement was discussed onsite with staff, Although referenced on page A3, this requirement language is missing in the SIU Antifraud Plan. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 52. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.5.2	The MCO shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the MCO or MCO employee, network providers, subcontractor or subcontractor employee or under the provisions of Section 1128(a) or (b) of the Social Security Act (42 U.S.C. 1320a-7) or any contractor which could result in exclusion, debarment, or suspension of the MCO, network provider or a subcontractor from the Medicaid or CHIP program, or any program listed in Executive Oder 12549.	FWA Compliance Plan	Full			
15.5.3	Reporting shall include, but is not limited to, as set forth in 42 CFR 455.17:					
15.5.3.1	Number of complaints of fraud, abuse, waste, neglect and overpayments made to the MCO that warrant preliminary investigation (under 42 CFR 455.14);	FWA Compliance Plan	Full			
15.5.3.2	Number of complaints reported to the Contract	FWA Compliance Plan	Full			

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Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	Compliance Officer; and					
15.5.3.3	For each complaint that warrants full investigation (defined at 42 CFR 455.15 and 455.16, the MCO shall provide LDH, at a minimum, the following: • Provider name and ID number; • Source of complaint; • Type of complaint; • Nature of complaint; • Approximate range of dollars involved if applicable; and • Legal and administrative disposition of the case and any other information necessary to describe the activity regarding the complainant.	FWA Compliance Plan	Full			
15.5.3	The MCO, through its compliance officer, shall attest to LDH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	FWA Compliance Plan Attestation Form	Full			
15.5.4	The MCO shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the MCO and all of its subcontractors. [See 42 CFR §438.608(d)(3)] .	FWA Compliance Plan Copies of quarterly reports	Full			
15.5.5	The MCO shall report all to LDH Program Integrity at least quarterly all unsolicited provider refunds, to include any payments submitted to the MCO and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.	FWA Compliance Plan Copies of quarterly reports	Full			
15.5.6	LDH shall utilize MCO overpayment and recovery data in calculating future capitation rates per 42 CFR §438.608(d)(4).					
15.6	**Medical Records**					
15.6.1	The MCO shall have a method to verify that services for which reimbursement was made, was provided to members as billed. The MCO shall have policies and procedures to maintain, or require	P/P for medical records P/P for medical record documentation	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	standards P/P for medical record monitoring Provider Manual Model Provider Contracts for all provider types				
15.6.1.1	Accurate and legible;	P/P for medical records P/P for medical record standards	Full			
15.6.1.2	Safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit; and	P/P for medical records P/P for medical record standards	Full			
15.6.1.3	Readily available for review and provides medical and other clinical data required for Quality and Utilization Management review.	P/P for medical records P/P for medical record standards	Full			
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	P/P for medical records P/P for medical record standards	Full			
15.6.2.1	Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);	P/P for medical records P/P for medical record standards	Full			
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	P/P for medical records P/P for medical record standards	Full			
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	P/P for medical records P/P for medical record standards	Full			
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or	P/P for medical records	Full			

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Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	P/P for medical record standards				
15.6.2.5	Referrals including follow-up and outcome of referrals;	P/P for medical records P/P for medical record standards	Full			
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	P/P for medical records P/P for medical record standards	Full			
15.6.2.7	Signed and dated consent forms (as applicable);	P/P for medical records P/P for medical record standards	Full			
15.6.2.8	Documentation of immunization status;	P/P for medical records P/P for medical record standards	Full			
15.6.2.9	Documentation of advance directives, as appropriate;	P/P for medical records P/P for medical record standards	Full			
15.6.2.10	Documentation of each visit must include: Date and begin and end times of service; Chief complaint or purpose of the visit; Diagnoses or medical impression; Objective findings; Patient assessment findings; Studies ordered and results of those studies (e.g. laboratory, x-ray, EKG); Medications prescribed; Health education provided; Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and Initials of providers must be identified with correlating signatures.	P/P for medical records P/P for medical record standards	Full			
15.6.2.11	Documentation of EPSDT requirements including but not limited to: Comprehensive health history; Developmental history; Unclothed physical exam; Vision, hearing and dental screening; Appropriate	P/P for medical records P/P for medical record standards	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	immunizations; Appropriate lab testing including mandatory lead screening; and Health education and anticipatory guidance.					
15.6.3	The MCO is required to provide one (1) free copy of any part of member's record upon member's request.	P/P for medical records	Full			
15.6.4	All documentation and/or records maintained by the MCO its subcontractors, and all of its network providers related to all services, charges, operations and agreements under this contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to a member or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.	P/P for medical records P/P for medical record retention	Full			
15.7	**Rights of Review and Recovery by MCO and LDH**					
15.7.1	The MCO and its subcontractors is responsible for investigating and reporting possible acts of provider fraud, abuse, and waste for all services under this contract,.	FWA Compliance Plan	Full			
15.7.2	The MCO and its subcontractors shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. The collected funds from these reviews are to remain with the MCO. The MCO shall report to LDH on a quarterly basis the results of all reviews, and include instances of suspected fraud, identified overpayments, and collection status. Notice to the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and referred to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH.	FWA Compliance Plan	Substantial This requirement is partially discussed in the Investigations of Suspected Fraud and Abuse document and overpayments are reported on the 145 Report. No documentation discussed the right to audit providers and members within a 5 year period. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review.	Full	This requirement is addressed within the SIU Antifraud Plan on page 65. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.7.3	All reviews shall be completed within eight months (240 calendar days) of the date the case was opened unless an extension is authorized by LDH. This review period is inclusive of all provider notifications, health plan document reviews, and includes any provider appeal or rebuttal process.	FWA Compliance Plan	Substantial The language is missing in the SIU Antifraud Plan. This requirement was discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 52. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.7.4	The MCO shall confer with LDH before initiating a post-payment provider-focused review to ensure that review and recovery is permissible. Notification of intent to review and/or recover shall include at a minimum: provider name, NPI, city and provider type, allegation or issue being reviewed, procedure codes or National Drug Codes (NDCs) under review, date range for dates of service under review, and amount paid. LDH shall respond within ten business days to each review notification. In the event LDH does not respond, the MCO may proceed with the review. The MCO and its subcontractors shall not pursue recovery until approved by LDH.	FWA Compliance Plan	Substantial This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. Post-payment is discussed in the Program Integrity Plan. This requirement was discussed onsite with staff. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 65. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
15.7.5	Contact with the provider shall be prohibited in instances resulting from suspected fraud, which the MCO has identified and submitted a referral of fraud to the Department, MFCU, or other appropriate law enforcement agency, unless approved by LDH	FWA Compliance Plan	Minimal This requirement language is missing in the March 2019 SIU Antifraud Plan although the requirement is referenced on page A3. This requirement was addressed onsite by the MCO, but the language was not found in submitted documentation. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 65. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.7.6	If the MCO fails to collect at least a portion of an identified recovery after 365 days from the date of the Department approved proceeding with the recoupment (per 15.1.17), unless an extension or exception is authorized by the Department, or the MCO has documented recovery efforts deemed sufficient by LDH upon review, including formally initiating collection efforts, the Department or its agent may recover the overpayment from the MCO and said funds will be retained by the State. Exception reasons may include, but are not limited to, MCO cooperation with LDH or other government agencies, termination of provider participation with the MCO, or dissolution of the provider's business.					
15.7.7	LDH or its agent shall have the right to audit and investigate providers and members within the MCO's network for a five (5) year period from the date of service of a claim. LDH may recover from	FWA Compliance Plan	Minimal This requirement language is partially addressed in the Overpayments Policy and is missing in the SIU Antifraud Plan although the	Full	This requirement is addressed within the SIU Antifraud Plan on page 65. An email dated 1/24/20 from LDH noted that the plan	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.		requirement is referenced on page A3. Missing from all documentation was the requirement of the right to audit within a 5 year period from the date of service of a claim. **Recommendation** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. MCO Response: Language has been added to the Anti-Fraud Plan and is currently in review with LDH.		was approved.	
15.7.8	LDH shall not initiate its own review on the same claims for a network provider which has been identified by the MCO as under a review approved by LDH per Section 15.7.4. LDH shall track open LDH and MCO reviews to ensure audit coordination. LDH shall not approve MCO requests to initiate reviews when the audit lead and timeframe is already under investigation by LDH or its agents.					
15.7.9	In the event LDH or its agent initiates a review on a network provider, a notification shall be sent to the MCO Special Investigation Unit (SIU) designee. The LDH notification of the intent to review shall include: provider name, NPI, city, and provider type, allegation or issue being reviewed, procedure codes or NDCs under review, date range for dates of service under review, and amount paid. The MCO shall have ten business days to indicate whether the claims were corrected or adjusted prior to the date of the notification from the Department. If the State does not receive a	FWA Compliance Plan	Substantial The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. An MCO Fraud Referral Template was provided to show evidence of compliance. Onsite, SIU unite confirmed they have a case tracking system. **Recommendation** The MCO should update the SIU Antifraud plan, which is in review with LDH, to include this requirement language.	Full	This requirement is addressed within the SIU Antifraud Plan on page 66. An email dated 1/24/20 from LDH noted that the plan was approved.	

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	response from the MCO within ten business days, the State may proceed with its review.		<u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.			
15.7.10	In the event the State or its agent investigates or audits a provider or member within the MCO's Network, the MCO shall comply with document and claims requests from the State within fourteen (14) calendar days of the request, unless another time period is agreed to by the MCO and State. Document requests do not include medical records that shall be obtained from the provider.	FWA Compliance Plan	Minimal The language is missing on the March 2019 SIU Antifraud Plan but is partially addressed by the Overpayments Policy. The 14 day timeliness of compliance with state requests is not written in any documentation. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 52. An email dated 1/24/20 from LDH noted that the plan was approved.	
15.7.11	LDH shall notify the MCO and the network provider concurrently of overpayments identified by the State or its agents.					
15.7.12	The MCO shall not correct claims not initiate an audit on the claims upon notification of identified overpayment by the Department or its agent unless directed to do so by the Department.	FWA Compliance Plan	Full			
15.7.13	In the event the provider does not refund overpayments identified by the Department of its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to the provider of the overpayment or where applicable, within thirty (30) calendar days of notification of the conclusion of the appeal process, the Department will notify the MCO and the MCO shall initiate a payment	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	withhold on the provider in the amount due to the Department. Upon LDH request, the MCO shall refund to the State any amounts collected . Any instances of a credit balance would be sustained by the MCO and/or Department until resolved or dismissed under Department rules.					
15.7.14	In the event LDH or its agent recovers funds from a provider due to an overpayment, the MCO shall submit corrected encounter data within thirty (30) calendar days upon notification by LDH, and shall not seek additional recovery from the provider for the claims the LDH or its agent audited, unless approved by LDH.					
15.7.15	The MCO and its subcontractors shall enforce LDH directives regarding sanctions on MCO network providers and members, up to termination or exclusion from the network.	FWA Compliance Plan	Full			
15.7.11	There will be no LDH provider improper payment recovery request of the MCO applicable for dates of service occurring before the start of the Medicaid Managed Care Contract period of for providers for which no MCO relationship existed.	FWA Compliance Plan	Minimal The requirement language is missing in the March 2019 SIU Antifraud Plan. Recoupments were discussed onsite with staff. **<u>Recommendation</u>** The MCO should obtain approval for the updated SIU Antifraud plan that contains the contract language and is in review with LDH. This can be presented at the next audit review. <u>MCO Response:</u> Language has been added to the Anti-Fraud Plan and is currently in review with LDH.	Full	This requirement is addressed within the SIU Antifraud Plan on page 52. An email dated 1/24/20 from LDH noted that the plan was approved.	
	Additional PE-Related RFP Sections					
4.1.2	For the purposes of this contract, the MCO shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549 [42 CFR §438.610(a) and (b), 42 CFR §1001.1901(b), 42 CFR §1003.102(a)(2)]. The MCO must screen all employees and sub-contractors to determine whether any of them have been excluded from participation in federal health care programs. The Health and Human Services-Office of Inspector General (HHS-OIG) website, which can be searched by the names of any individual, can be accessed at the following url: https://oig.hhs.gov/exclusions/index.asp.					
4.1.4	The MCO shall comply with LDH Policy 8133-98, "Criminal History Records Check of Applicants and Employees," which requires criminal background checks to be performed on all employees of LDH contractors who have access to electronic protected health information on Medicaid applicants and recipients. It shall, upon request, provide LDH with a satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed for any of its staff or subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.	FWA Compliance Plan	Full			
4.2.1.6	Annually, the MCO must provide the name, Social Security Number and date of birth of the staff members performing the duties of the key staff. LDH will compare this information against federal databases to confirm that those individuals have not been banned or debarred from participating in federal programs [42 CFR §455.104].	FWA Compliance Plan	Full			
7.6.2	The MCO shall not execute contracts with individuals or groups of providers who have been excluded from participation in Federal health care	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

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Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	programs under either Section 1128 or Section 1128A of the Social Security Act [42 CFR §438.214(d)] or state funded health care programs. The list of providers excluded from federally funded health care programs can be found at http://exclusions.oig.hhs.gov/ and the System for Award Management, https://www.sam.gov/index.html/ , and Health Integrity and Protection Data Bank at http://www.npdb- hipdb.hrsa.gov/index.jsp.					
7.13.6	The MCO shall not execute provider subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §1128 of the Social Security Act (42 U.S.C. §1320a-7) or §1156 of the Social Security Act (42 U.S.C. §1320c-5) or who are otherwise barred from participation in the Medicaid and/or Medicare program. The MCO shall not enter into any relationship with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			
9.5.5	The MCO shall not pay any claim submitted by a provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The MCO shall not pay any claim submitted by a provider that is on payment hold under the authority of LDH or its authorized agent(s).	FWA Compliance Plan	Substantial This requirement is not addressed by the Provider Garnishment Desktop Procedure as the provided document pertains to Kentucky requirements, not Louisiana. **<u>Recommendation</u>** The MCO should produce a Provider Garnishment Desktop Procedures or payment suspension policy addressing Louisiana requirements. <u>MCO Response:</u>	Full	This requirement is partially addressed in the Provider Hold Flow Diagram. LHC presented a draft version of the Louisiana Provider Payment Suspension (Hold) Policy but it is in draft form dated 3/11/20. As follow up Healthy Blue provided email confirmation of their submission and LDH approval. However, the request for approval was made on 3/20/20 with only 11 days left in the review period.	This requirement was included in the Notice of Action/Final Technical Report received from LDH based on the 2019 EQRO review findings. This NOA was issued 2/14/2020 with a response timeline of 30 – 60 days. Healthy blue responded within 30 days , 3/12/2020. Healthy Blue submitted

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Overpayments Policy – Full Document Provider Hold Process – Full Document Payment suspension policy is being created specific to LA **Final Review Determination** The determination was changed to Substantial. Based on the response provided by Healthy Blue, we found this requirement is evidenced by the Provider Hold Flow Diagram, and a review of notes from the onsite show staff have knowledge about the processes of payment holds and overpayments. However, a payment suspension policy specific to Louisiana should be developed.		**Final Review Determination** Based on the Notice of Action issuance date of 02/14/2020, Healthy Blue's response submitted for approval within the 30-60 day timeframe imposed by LDH, and subsequent approval by LDH, the determination has been changed to Full.	the policy to LDH for approval after submission of our response to the NOA. LDH approved the NOA response and closed this on 7/31/2020.
17.2.6.1.9	**Provider Validation –** Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted and that the provider has not been excluded from receiving Medicaid payments as stipulated in Section 9.4	FWA Compliance Plan	Full			
18.1	Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs (42 CFR §455.100-455.106.) The **Medicaid Ownership and Disclosure Form** (Appendix VV) is to be submitted to LDH with the proposal; then resubmitted prior to implementation for each Contract period, annually, and within thirty-five (35) days when any change in the MCO's management, ownership or control occurs.	FWA Compliance Plan	Full			
18.2	**Information Related to Business Transactions -** 18.2.1 The MCO shall furnish to LDH and/or to the HHS, information related to significant business transactions as set forth in 42 CFR §455.105. Failure to comply with this requirement may result in	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	termination of this Contract. 18.2.2 The MCO shall submit, within thirty-five (35) days of a request made by LDH, full and complete information about: 18.2.2.1 The ownership of any subcontractor with whom the MCO has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of this request; and 18.2.3 Any significant business transactions between the MCO and any wholly owned supplier, or between the MCO and any subcontractor, during the five (5) year period ending on the date of this request. 18.2.4 For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any state fiscal year that exceed the $25,000 or five (5%) percent of the MCO's total operating expenses whichever is greater.					
18.3	**Report of Transactions with Parties in Interest –** 18.3.1 The MCO shall report to LDH all "transactions" with a "party in interest" (as such terms are defined in Section 1903(m)(4)(A) of the Social Security Act and SMM 2087.6(A-B)), as required by Section 1903(m)(4)(A) of the Social Security Act. 18.3.2 Federally qualified MCOs are exempt from this requirement. LDH may require that the information on business transactions be accompanied by a consolidated financial statement for the MCO and the party in interest.	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	**Contract Requirement Language**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	18.3.3 If the MCO has operated previously in the commercial or Medicare markets, information on business transactions for the entire year preceding the initial contract period must be disclosed. 18.3.4 The business transactions that must be reported are not limited to transactions related to serving the Medicaid enrollment. All of the MCO's business transactions must be reported. 18.3.5 If the contract is renewed or extended, the MCO must disclose information on business transactions which occurred during the prior contract period.					
18.7	The MCO shall furnish LDH information related to any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106. Failure to comply with this requirement may lead to termination of this Contract.	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			
25.13.1	**Debarment, Suspension, Exclusion -** 25.13.1 The MCO agrees to comply with all applicable provisions of 2 CFR Part 376, pertaining to non-procurement debarment and/or suspension. As a condition of enrollment, the MCO must screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and/or all federal health care programs. To help make this determination, the MCO may search the following websites: • Office of Inspector General (OIG) List of Excluded Individuals/Entities) LEIE https://oig.hhs.gov/exclusions/index.asp; the Health Integrity and Protection Data Bank (HIPDB) • http://www.npdb-hipdb.hrsa.gov/index.jsp;	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	• the Louisiana Adverse Actions List Search (LAALS), https://adverseactions.LDH.la.gov/; and/or • the System for Award Management, http://www.sam.gov .					
25.13.2	The MCO shall conduct a screen, as described in Section 25.12.1 monthly to capture exclusions and reinstatements that have occurred since the last search and any exclusion information discovered should be immediately reported to LDH. Any individual or entity that employs or subcontracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil liquidated damages may be imposed against providers who employ or enter into provider contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A (a) (6) of the Social Security Act and 42 CFR §1003.102(a)(2).	FWA Compliance Plan	Full			
25.41	**Prohibited Payments -** Payment for the following shall not be made: Organ transplants, unless the state plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual; Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not	FWA Compliance Plan				

Fraud, Waste and Abuse						
Contract | RFP Reference	Contract Requirement Language	Suggested Documentation and reviewer instructions	Prior Review Results	Review Determination	Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)	MCO Response and Plan of Action
	covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.					

Core Benefits and Services

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.4	**Behavioral Health Services**					
6.4.5 6.4.5.1	**Permanent Supportive Housing** LDH partners with the Louisiana Housing Authority (LHA) to co-manage the Louisiana Permanent Supportive Housing (PSH) program. PSH provides deeply affordable, community-integrated housing paired with tenancy supports that assist persons with disabilities to be successful tenants and maintain stable housing. The Louisiana PSH program is a cross-disability program that provides access to over 3,300 affordable housing units with rental subsidies statewide. In Louisiana, PSH services are reimbursed under several Medicaid HCBS programs, and under specialized behavioral health State Plan services where it is billed as a component of CPST and PSR. However, Medicaid Managed Care members must meet PSH program eligibility criteria, in addition to medical necessity criteria for services in order to participate in PSH http://new.dhh.louisiana.gov/index.cfm/page/1732/n/388 Overall management of the PSH program is centralized within LDH and final approval for members to participate in PSH is made by the LDH PSH program staff. For the Louisiana PSH program, the MCO shall:					
6.4.5.1.1	Provide outreach to qualified members with a potential need for PSH;	Member letters Member handbook P/P member education	Full			
6.4.5.1.2	Assist members in completing the PSH program application;	Member letters Member handbook P/P member education	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
6.4.5.1.3	Within one (1) working day of request by designated LDH PSH program staff, provide accurate information about status of eligibility assessment, determination, and recertification;	Communications to LDH P/P education	Full			
6.4.5.1.8	Report on PSH outreach monthly and quarterly using a format to be provided by the LDH PSH program manager; and	Completed LDH template	Full			
6.4.5.2	To assure effective accomplishment of the responsibilities required per Section 6.4.5.1 the MCO shall:					
6.4.5.2.1	Identify a PSH program liaison, to be approved by LDH, to work with LDH PSH program staff to assure effective performance of MCO responsibilities and requirements, effective implementation and delivery of PSH services, and to address problems or issues that may arise.	Organizational chart	Full			
6.4.9	The MCO shall provide guidelines, education and training, and consultation to PCPs to support the provision of basic behavioral health services in the primary care setting.	Training slides P/P provider education Provider handbook	Full			
6.4.9.1	The MCO shall ensure network providers utilize behavioral health screening tools and protocols consistent with industry standards. The MCO shall work to increase screening in primary care for developmental, behavioral, and social delays, as well as screening for child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO may provide technical assistance to providers, incentives, or other means to increase screening for behavioral health needs in primary care.	Provider handbook Provider education materials Provider contracts P/P provider education	Full			
6.4.9.2	The MCO shall work to increase provider	P/P provider education	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	utilization of consensus guidelines and pathways for warm handoffs and/or referrals to behavioral health providers for children who screen positive for developmental, behavioral, and social delays, as well as child maltreatment risk factors, trauma, and adverse childhood experiences (ACEs). The MCO shall work to increase the percentage of children with positive screens who: 1) receive a warm handoff to and/or are referred for more specialized assessment(s) or treatment and 2) receive specialized assessment or treatment.	Provider handbook				
6.4.10	Develop crisis intervention and stabilization services to better manage behavioral health issues in the community. The MCO shall maintain an active role in managing the process to ensure resolution of behavioral health crises in the community and referral to and assistance with placement in behavioral health services required by the individual in need. Regional crisis community collaborations consist of an array of public and private partners such as law enforcement, emergency department directors, psychiatric acute unit directors, coroners, behavioral health advocates, and peer supports. The MCO shall familiarize itself with the local crisis collaborative and work with it to facilitate crisis resolution.	P/P behavioral integration Communications with community agencies	Full			
6.8						
6.8.1 6.8.1.1	**Emergency Medical Services** The MCO shall provide that emergency services, including those for specialized behavioral health, be rendered without	Member handbook P/P ER services	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	the requirement of prior authorization of any kind. The MCO must cover and pay for emergency services regardless of whether the provider that furnishes the emergency services has a contract with the MCO. If an emergency medical condition exists, the MCO is obligated to pay for the emergency service.					
6.8.1.2	The MCO shall advise all Medicaid MCO members of the provisions governing in and out-of-service area use of emergency services as defined in the Glossary.	Member handbook	Full			
6.8.1.3	The MCO shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services.	Member handbook P/P Member services	Full			
6.8.1.4	The MCO shall not deny payment for treatment obtained when a member had an emergency medical condition as defined in 42 CFR §438.114(a), nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.	Member handbook P/P emergency services	Full			
6.8.1.5	The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member shall determine when the member is sufficiently stabilized for transfer or discharge and that determination is binding on the MCO for coverage and payment.	Provider handbook P/P Care coordination	Full			
6.8.1.6	If there is a disagreement between a hospital or other treating facility and an MCO concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency	P/P Coordination of services Communications to hospital	Full			

Core Benefits and Services						
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	physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the MCO. This subsection shall not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.					
6.8.1.7	The MCO will include in the proposal a plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to LDH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.	P/P Coordination of Services Quality of core plan Member handbook	Full			
6.8.1.8	The MCO shall be responsible for educating members and providers regarding appropriate utilization of ED services, including behavioral health emergencies.	Member & provider handbook Educational materials	Full			
6.8.1.9	The MCO shall monitor emergency services utilization by provider and member and shall have routine means for redressing inappropriate emergency department utilization. For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health	P./P Emergency services Member handbook	Full			

Core Benefits and Services						
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	and medicine.					
6.8.1.10	A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Member handbook	Full			
6.8.2 6.8.2.1.	**Post Stabilization Services** As specified in 42 CFR §438.114(e) and 42 CFR §422.113(c)(2)(i), (ii) and (iii), the MCO is financially responsible for post-stabilization care services obtained within or outside the MCO that are:					
6.8.2.1.1	Pre-approved by a network provider or other MCO representative; or	P./P post stabilization services	Full			
6.8.2.1.2	Not preapproved by a network provider or other MCO representative, but:	P./P post stabilization services	Full			
6.8.2.1.2.1	Administered to maintain the member's stabilized condition within one (1) hour of a request to the MCO for pre-approval of further post-stabilization care services or	P./P post stabilization services	Full			
6.8.2.1.2.2	Administered to maintain, improve or resolve the member's stabilized condition if the MCO: • Does not respond to a request for pre-approval within one hour; • Cannot be contacted; or • MCO's representative and the treating physician cannot reach an agreement concerning the member's care and a network physician is not available for consultation. In this situation, the MCO must give the treating physician the opportunity to consult with a network physician and the treating physician may continue with care of the patient until a network physician is reached or one of the criteria of (422.133(c)(3)) is met.	P./P post stabilization services Provider handbook	Full			

Core Benefits and Services						
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6.8.2.2	The MCO's financial responsibility for post-stabilization care services that it has not pre-approved ends when:	P./P post stabilization services				
6.8.2.2.1	A network physician with privileges at the treating hospital assumes responsibility for the member's care;	P./P post stabilization services	Full			
6.8.2.2.2	A network physician assumes responsibility for the member's care through transfer;	P./P post stabilization services	Full			
6.8.2.2.3	A representative of the MCO and the treating physician reach an agreement concerning the member's care; or	P./P post stabilization services	Full			
6.8.2.2.4	The member is discharged.	P./P post stabilization services	Full			
6.16	**Sterilization**					
6.16.2	Sterilization must be conducted in accordance with Louisiana R.S. 40:1159.2, state Medicaid policy, federal regulations contained in 42 CFR §441.250 - 441.259. All procedures must be documented with a completed Sterilization Consent Form OMB 0937-0166.	P/P Sterilization Services Member Handbook/website Provider Manual/portal	New Requirement	Full	This requirement is addressed in the Women's Health and Family Planning Services-LA Policy and Procedures, in the Healthy Blue Member Handbook on page 36, and on page 35 of the Healthy Blue Provider Manual; however, the latter document appears to be a draft version with tracked changes in sections other than those that address this requirement. In an email from Hassan Gardezi to Carolyn Gallagher dated 7/30/20, the plan explained that "The manual has tracked changes because this is how it was submitted to LDH in response to the last EQRO audit. Since we haven't received a final response/approval from them, we provided you with the same version." In follow-up to the interview, the MCO provided an email, dated 1/9/2020 from Kimberly	

Core Benefits and Services						
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					Chope to Whitney Martinez with the Provider Manual attached, revised per Whitney Martinez' email dated 12/26/19.	
6.19	**Services for Special Populations**					
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any age with mental disability, physical disability, or other circumstances that place their health and ability to fully function in society at risk, requiring individualized health care approaches. For the behavioral health population, individuals with special health care needs include:					
6.19.1.1	Individuals with co-occurring mental health and substance use disorders;					
6.19.1.2	Individuals with intravenous drug use;					
6.19.1.3	Pregnant women with substance use disorders or co-occurring disorders including but not limited to pregnant women who are using alcohol, illicit or licit drugs such as opioid and benzodiazepines or at risk of delivering an infant affected by neonatal abstinence syndrome (NAS) or fetal alcohol syndrome;					
6.19.1.4	Individuals with substance use disorders who have dependent children;					
6.19.1.5	Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC;					
6.19.1.6	Nursing facility residents approved for specialized behavioral health services recommended as a result of PASRR Level II determination;					
6.19.1.7	Adults, 18 years or older, receiving mental					

Core Benefits and Services						
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	health rehabilitation services under the state plan and children/youth who qualify for CSoC as assessed by the CSoC program contractor and have declined to enter or are transitioning out of the CSoC program.					
6.19.1.8	Individuals with 2 or more inpatient or 4 or more ED visits within the past 12 months;					
6.19.1.9	Individuals with co-occurring behavioral health and developmental disabilities;					
6.19.1.10	Individuals diagnosed with Autism Spectrum Disorder (ASD) or at risk of an ASD diagnosis;					
6.19.1.11	Newly diagnosed adolescents and young adults, 15-30 years of age, who experience first signs of symptom onset for serious mental illness, such as schizophrenia, bipolar disorder, and/or major depression; and					
6.19.1.12	Persons living with HIV/AIDS and who are in need of mental health or substance use early intervention, treatment, or prevention services.					
6.19.2	The MCO shall identify members with special health care needs within ninety (90) days of receiving the member's historical claims data (if available). LDH may also identify special healthcare members and provide that information to the MCO. The LMHP or PCP can identify members as having special needs at any time the member presents with those needs. The MCO must assess those members within ninety (90) days of identification, with the exception of individuals referred for PASRR Level II, who shall be evaluated within federally	HRA P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review	Full			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	required timelines as per Section 6.38.5.4. The assessment must be done by appropriate healthcare professionals. Assessments that determine a course of treatment or regular care monitoring as appropriate shall result in a referral for case management.					
6.19.3	The mechanisms for identifying members with special health care needs (SHCN) that require an assessment to determine if a course of treatment or regular care monitoring is needed are as follows: .1 The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, LDH approved, guidelines for SHCN criteria. .2 MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. .3 Members may self-identify to either the Enrollment Broker or the MCO that they have special health care needs. The Enrollment Broker will provide notification to the MCO of members who indicate they have special health care needs. .4 Members may be identified by LDH and that information provided to the MCO.	P/P members with Special Health Needs Documentation of assessment conducted Includes Case Management File Review	Full			
6.19.4	**Individualized Treatment Plans and Care Plans** All SHCN members shall be referred for, and if found eligible, offered case management, including an individualized treatment plan developed by the treating provider(s)and a person-centered plan of care developed by the MCO care manager. The individualized treatment plans must	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review	Substantial This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5 and in the 2019 CM Program Description on page 24. **<u>File Review Results</u>** Of the 10 case management files reviewed, 10 had a care plan, including the 8	Full	This requirement is addressed in the Special Health Care Needs Population – LA Policies and Procedures on page 4. **<u>File Review Results</u>** Of the 10 case management files reviewed, the requirement for a care plan based on the needs assessment	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
	be:		identified as having special needs. Ten (10) of 10 care plans were developed with member and/or family involvement. Ten (10) of 10 members had care plans with short- and long-term goals. Of the 10 behavioral health case management files reviewed, the requirement for a plan of care based on the needs assessment was applicable to 8 members. There were 2 members without a plan of care for whom the individualized plan of care requirement was deemed not applicable—the first due to multiple unsuccessful member contact attempts and the second due to CSoC enrollment. However, the case management record documented care planning that included member demographics, member goals, supports and services, and a plan for addressing crisis/preventing unnecessary hospitalizations for 10 of 10 files reviewed. Of 8 applicable files, 7 met the requirement for an individualized plan of care based on the needs assessment. The one member who did not meet the individualized care plan requirement did have a care plan; however, the care plan addressed the behavioral health diagnosis, but not the type 1 diabetes diagnosis. The care coordination notes did address ongoing interventions to address the diabetes diagnosis, including PCP visits; however, care coordination notes also documented a HEDIS alert HbA1c > 9 pending without follow-up, and this young adult member expired in the hospital due to complications of type 1 diabetes.		was not applicable to 1 file as the member's care needs were met with no unmet goals. Nine (9) of the 9 applicable files did have a care plan with short- and long-term goals, and these 9 files included 7 members with special health care needs. Ten (10) of the 10 behavioral health case management files reviewed had a care plan based on the needs assessment, and all 10 met the requirement to include member demographics, member goals, supports and services, and a plan for addressing crisis.	

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			Recommendation There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses physical health, as well as behavioral health. In addition, an enhanced process for sharing the plan of care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, including timely follow-up on HEDIS alerts, such as the HbA1C > 9. MCO Response: An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the			

Core Benefits and Services						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.114, 438.208)**	**Suggested Documentation and reviewer instructions**	**Prior Review Results**	**Review Determination**	**Comments (Note: For any element that is less than fully compliant, an explanation of the finding and a recommendation must be documented below)**	**MCO Response and Plan of Action**
			HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing the plan of care as recommended.			
6.19.4.1	Developed by the member's primary care provider and/or other lead provider as appropriate, with member participation, and in consultation with any specialists caring for the member. For SHCN members, the treatment plan shall be submitted to the member's MCO no later than 30 days following the completion of the initial assessment or annual reassessment.	Treatment plan P/P Individual Treatment Plans Documentation of communication Includes Case Management File Review	Full			
6.19.4.2	In compliance with applicable quality assurance and utilization management standards:	P/P Individual Treatment Plans				
6.19.4.3	Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member; and	P/P Individual Treatment Plans Plan of Care Includes Case Management File Review	Substantial This requirement is addressed in the Special Healthcare Needs Population – LA Policy and Procedure on page 5, and implementation is supported by the Care Plan document. **File Review Results** Of the 10 case management files for members with care plans, 2 were unable to be contacted by CM for follow-up due to multiple unsuccessful contacts. Of the 8 applicable files, 8 met the requirement for ongoing review and revision as indicated. The requirement for monitoring of	Full	This requirement is addressed in the Special Health Care Needs Population – LA Policies and Procedures on page 4. **File Review Results** Of the 9 case management files for members with care plans, 1 was not applicable for follow-up because the member expired in the hospital. Eight (8) of the applicable 8 files met the requirements for monitoring of outcomes and revision of care plan. Ten (10) of the 10 behavioral health	

Core Benefits and Services						
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			outcomes was applicable to 9 of the 10 behavioral health case management files, as 1 was excluded due to multiple unsuccessful outreach attempts. Although the requirement for a care plan was deemed not applicable for the 1 member enrolled in CSoC, ongoing monitoring of outcomes was documented for this member in the care coordination notes. Nine (9) of the 9 files met the requirement for monitoring of outcomes. Seven (7) of 8 applicable files met the requirement for revision of the treatment plan as necessary. The 1 file that did not meet this requirement did document revision of the care plan for the behavioral health diagnosis, but not for diabetes; consequently, the care plan was not revised to address the HEDIS alert HbA1c > 9 and care coordination notes indicated that status for this alert was pending. **Recommendation** There is an opportunity to improve care coordination by ensuring that the plan of care comprehensively addresses ongoing monitoring of both physical health and behavioral health, with revisions made to address changing physical health and behavioral health needs. In addition, an enhanced process for sharing the plan of care among behavioral health and physical health care managers is merited to improve communication between behavioral health case managers, as well as specialist behavioral health teams (i.e., assertive community treatment) and physical health case managers, particularly		case management files with care plans met the requirement for monitoring of outcomes. The requirement for revision of the care plan was not applicable to two members: one who was being followed by the ACT Team navigator and the other who the case manager was unable to contact after that member left the group home. Of the applicable 8 files, 8 met the requirement for revision of the care plan.	

Core Benefits and Services						
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			timely follow-up on HEDIS alerts, such as the HbA1C > 9. MCO Response: An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) the HbA1C>9 HEDIS measure was not included in the list of measures in the education document provided, (3) sending an education document is a passive, not a robust intervention, and (4) the MCO did not detail actions taken to develop and implement an enhanced process for sharing and revising the plan of care on an ongoing basis as recommended.			
6.19.4.4	A person-centered integrated plan of care developed by the MCO care manager shall be completed within thirty (30) calendar days of provider treatment plan development that includes all medically	P/P Individual Treatment Plans Plan of Care	Full			

Core Benefits and Services						
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	necessary services including specialized behavioral health services and primary care services identified in the member's treatment plans (individualized treatment plans are developed by the provider(s)) and meet the requirements above.					
6.28	**Care Management**					
6.28.1	Care management is defined as the overall system of medical management, care coordination, continuity of care, care transition, chronic care management, and independent review. The MCO shall ensure that each member has an ongoing source of primary and/or behavioral healthcare appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating Medicaid covered services provided to the member.	CM records Member Handbook	Full			
6.28.2 6.28.2.1	The MCO shall be responsible for ensuring: Member's health care needs and services/care are planned and coordinated through the MCO PCP and/or behavioral health provider;	P/P member Services Provider handbook Includes Care Management File Review	Full			
6.28.2.2	Accessibility of services and promoting prevention through qualified providers and medical home practices in accordance with 42 CFR §438.6(k) which requires the provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and	P/P member Services Call center documentation	Full			
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify	CM records P/P for care coordination	Substantial This requirement is addressed in the Behavioral Health Continuity and	Full	This requirement is addressed in the Behavioral Health Continuity and Coordination of Care – LA Policy and	

Core Benefits and Services						
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	appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	Includes Care Management File Review	Coordination of Care – LA Policy and Procedure on page 8, and the Coordination of Care –- LA Policy and Procedure addresses face-to-face engagement for high-risk members or otherwise difficult to reach on page 5, as well as in the Case Management Face-to-Face Intervention-LA Policy and Procedure. **File Review Results** Of the 10 files reviewed, 1 was not applicable due to multiple unsuccessful attempts to contact the member. Of the 9 applicable files, 9 met the general care coordination requirement, including the 8 identified as having special needs. Eight (8) files documented indications for referral, and 8 referrals were made. Of the 9 applicable files, there were 4 with BH diagnoses, and all 4 received care coordination that integrated BH with PH health. Of the 9 applicable files, there were 7 members for whom coordination with the Chronic Care Management Program was applicable and, of these 7, 6 met this requirement. The 1 file that did not meet this requirement was a high-risk pregnancy case with chronic disease other than hypertension/preeclampsia currently monitored as a Prematurity Extension PIP Intervention Tracking Measure (ITM). Of the 10 behavioral health case management files, 10 met the requirements for care coordination, release of information to coordinate with the PCP, and for referrals as indicated.		Procedure on page 8, and the Coordination of Care –- LA Policy and Procedure addresses face-to-face engagement for high-risk members or otherwise difficult to reach on page 5, as well as in the Case Management Face-to-Face Intervention-LA Policy and Procedure. **File Review Results** Ten of 10 case management files reviewed met the care coordination requirement, as well as the requirement for coordination with the Chronic Care Management Program and the requirement for making referrals. Ten of 10 behavioral case management files reviewed met the care coordination requirement, as well as the requirement for coordination with the Chronic Care Management Program and the requirement for making referrals.	

Core Benefits and Services						
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			Coordination with the Chronic Care Management Program was applicable to 8 of the 10 files, and 8 of 8 met this requirement. **Recommendation** The MCO should enhance and monitor care management for high-risk pregnant women with chronic physical conditions, not limited to hypertension/preeclampsia. MCO Response: An education station was sent to the entire case management department. The team member read the document, then attested to understanding the document. Documents to support are as follows (Full document): • Attestation Rebuttal • Education Station-Case Management Update **Final Review Determination** No change in determination. IPRO reviewed the case management education document, dated August 12, 2019, that was sent to the entire case management department and attestation; however, this does not meet the requirement because (1) the action was taken after the review period, (2) sending an education document is a passive, not a robust intervention, and (3) the MCO did not detail actions taken to develop and implement an enhanced process for care management as recommended.			
6.28.2.4	Patients with a condition that causes	Pain management plans	Full			

Core Benefits and Services						
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	chronic pain and have five (5) or more ED visits in the most recent 12-month period for chief complaint of pain are contacted by the MCO for a pain management plan and this plan will be shared with the patients' PCP, the patient, and relevant ED staff	P/P for care coordination Includes Care Management File Review				
6.30						
6.30.0	The MCO shall develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO shall establish a process to coordinate the delivery of core benefits and services with services that are reimbursed on a fee-for-service basis by LDH, provided by LDH's dental benefit program manager, or provided by community and social support providers. The MCO shall ensure member-appropriate provider choice within the MCO and interaction with providers outside the MCO. Continuity of care activities shall ensure that the appropriate personnel, including the service providers, are kept informed of the member's treatment needs, changes, progress or problems. These MCO activities and processes shall be demonstrated via workflows with specific decision points and provided to LDH by January 11, 2016. Continuity of care activities shall provide processes by which MCO members and network and/or non-network provider interactions are effective and shall identify	P/P for care coordination P/P for PCP choice Member survey Detailed Workflows	Full			

Core Benefits and Services						
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	and address those that are not effective. The MCO shall ensure that service delivery is properly monitored through member surveys, medical and treatment record reviews, and EOBs to identify and overcome barriers to primary and preventive care that a MCO member may encounter. Corrective action shall be undertaken by the MCO on an as needed basis and as determined by LDH.					
6.30.1	The MCO shall be responsible for the coordination and continuity of care of healthcare services for all members consistent with 42 CFR §438.208. In addition, the MCO shall be responsible for coordinating with the Office of Citizens with Developmental Disabilities for the behavioral health needs of the I/DD co-occurring population.	P/P for care coordination	Full			
6.30.2	The MCO shall implement LDH approved care coordination and continuity of care policies and procedures that meet or exceed the following requirements:					
6.30.2.1	Ensure a best effort is made to conduct an initial screening of the member's needs within ninety (90) days of their enrollment date for all new members. If the initial attempt is unsuccessful, subsequent attempts shall be made within the ninety (90) day time period;	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.2	Ensure that each member has an ongoing source of preventive and primary care appropriate to their needs;	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.3	Ensure each member is provided with	P/P for care	Full			

Core Benefits and Services						
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	information on how to contact the person designated to coordinate the services the member accesses;	coordination Includes Care Management File Review				
6.30.2.4	Coordinate care between network PCPs and specialists; including specialized behavioral health providers;	P/P for care coordination	Full			
6.30.2.5	Coordinate care for out-of-network services, including specialty care services;	P/P for care coordination	Full			
6.30.2.6	Coordinate MCO provided services with services the member may receive from other health care providers;	P/P for care coordination	Full			
6.30.2.7	Upon request, share with LDH or other health care entities serving the member with special health care needs the results and identification and assessment of that member's needs to prevent duplication of those activities;	P/P for care coordination	Full			
6.30.2.8	Ensure that each provider furnishing services to the member maintains and shares the member's health record in accordance with professional standards;	P/P for care coordination Provider Handbook	Full			
6.30.2.9	Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR Parts 160 and 164, and other applicable state or federal laws;	P/P for care coordination	Full			
6.30.2.10	Maintain and operate a formalized hospital and/or institutional discharge planning program;	P/P for care coordination Includes Care Management File Review	Full			
6.30.2.11	Coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including	P/P for care coordination	Full			

Core Benefits and Services						
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	aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:	Includes Care Management File Review				
6.30.2.11.1.	Behavioral health pharmacy prior authorization decisions are rendered before a member is discharged from a behavioral health facility (including, but not limited to, inpatient psychiatric facilities, PRTF's, and residential substance use disorder settings).	P/P for care coordination	Full			
6.30.2.11.2.	Care managers follow-up with members with a behavioral health related diagnosis within 72 hours following discharge.	P/P for care coordination CM records Includes Care Management File Review	Full			
6.30.2.11.3.	Coordination with LDH and other state agencies following an inpatient, PRTF, or other residential stay for members with a primary behavioral health diagnosis occurs timely when the member is not to return home.	P/P for care coordination	Full			
6.30.2.11.4	Members approaching the end of medical necessity/continued stay for PRTF or TGH have concrete and proactive discharge plans in place, including linkage with aftercare providers to address the member's treatment needs in the member's next recommended level of care or living situation. Concrete and proactive discharge plans, including linkage with aftercare providers in the member's next	P/P for care coordination Includes Care Management File Review	Full			

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	LOC or living situation, should be in place thirty (30) calendar days prior to discharge from a PRTF or TGH. The MCO shall follow up and coordinate with the discharging PRTF or TGH, receiving provider(s), and the member/guardian to ensure that the member is contacted by and is receiving services from aftercare providers as per the member's discharge plan.					
6.30.2.12	Document authorized referrals in its utilization management system;	P/P for care coordination	Full			
6.30.2.13	Provide active assistance to members receiving treatment for chronic and acute medical conditions or behavioral health conditions to transition to another provider when their current provider has terminated participation with the MCO. The MCO shall provide continuation of such services for up to ninety (90) calendar days or until the member is reasonably transferred without interruption of care, whichever is less:	P/P for care coordination	Full			
6.30.2.14	Coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of LDH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing; and	P/P care coordination Court proceedings	Full			
6.30.2.15	For the behavioral health population, provide aftercare planning for members prior to discharge from a 24-hour facility.	P/P care coordination	Full			
6.36						
6.36.1	The PCP shall provide basic behavioral	P/P for BH care	Full			

Core Benefits and Services						
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	health services (as described in this Section) and refer the member(s) to the appropriate health care specialist as deemed necessary for specialized behavioral health services.	continuity Provider contract Provider manual/handbook				
6.36.2	The MCO shall establish policies and procedures to facilitate the integration of physical and behavioral health and to provide for the appropriate continuity of care across programs. Principles that guide care integration are as follows: • Mental illness and addiction are healthcare issues and must be integrated into a comprehensive physical and behavioral healthcare system that includes primary care settings; • Many people suffer from both mental illness and addiction. As care is provided, both illnesses must be understood, identified, and treated as primary conditions; • The system of care will be accessible and comprehensive, and will fully integrate an array of prevention and treatment services for all age groups. It will be designed to be evidence-informed, responsive to changing needs, and built on a foundation of continuous quality improvement; • It is important that relevant clinical information is accessible to both the primary care and behavioral health providers consistent with federal and state laws and other applicable standards of medical record confidentiality and the protection of patient privacy.	P/P for BH care continuity	Full			

Core Benefits and Services						
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6.36.3	In any instance when the member presents to the network provider, including calling the MCO's toll-free number listed on the Member's ID card, and a member is in need of emergency behavioral health services, the MCO shall instruct the member to seek help from the nearest emergency medical provider. The MCO shall initiate follow-up with the member within forty-eight (48) hours for follow-up to establish that appropriate services were accessed.	P/P for BH care continuity Communication member	Full			
6.36.4	The MCO shall comply with all post stabilization care service requirements found at 42 CFR §422.113.	P/P for BH care continuity	Full			
6.36.5	The MCO shall include documentation in the member's medical record that attempts are made to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's behavioral health and primary care provider.	P/P for BH care continuity	Full			
6.36.6	The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity, as well as, cost-effectiveness of care.	P/P for BH care continuity	Full			
6.36.7	These procedures must address members with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.	P/P for BH care continuity	Full			
6.36.8	The MCO shall provide or arrange for training of providers and care managers on	P/P for BH care continuity	Full			

Core Benefits and Services						
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	identification and screening of behavioral health conditions and referral procedures.					
6.36.9 6.36.9.1.1 6.36.9.1.2 6.36.9.1.3 6.36.9.1.4	The MCO shall work with to strongly support the integration of both physical and behavioral health services through: • Enhanced detection and treatment of behavioral health disorders in primary care settings; • Coordination of care for members with both medical and behavioral health disorders, including promotion of care transition between inpatient services and outpatient care for members with co- existing medical-behavioral health disorders; • Assisting members without a diagnosed behavioral health disorder, who would benefit from psychosocial guidance in adapting to a newly diagnosed chronic medical disorder; • Utilization of approved communication and consultation by PCPs with behavioral health providers of co-enrolled members with co-existing medical and behavioral health disorders requiring co-management.	P/P for BH care coordination	Full			
6.36.9.1.5	Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.	P/P provider contracting Provider contracts	Full			
6.36.9.1.6	Distributing Release of Information forms as per 42 CFR §431.306, and provide training to MCO providers on its use.	Provider portal/handbook Training materials	Full			
6.36.9.1.7	Educating MCO members and providers	Member/provider	Full			

Core Benefits and Services						
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	regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	handbook Educational materials				
6.36.9.1.8	Identifying those who use emergency department (ED) services to assist in scheduling follow-up care with PCP and/or appropriate contracted behavioral health specialists;	P/P coordination of care	Full			
6.36.9.1.9	Ensuring continuity and coordination of care for members who have been screened positive or determined as having need of specialized medical health services or who may require inpatient/outpatient medical health services. These activities must include referral and follow-up for member(s) requiring behavioral health services.	P/P coordination of care	Full			
6.36.9.1.10	Documenting authorized referrals in the MCO's clinical management system;	Clinical management system records	Full			
6.36.9.1.11	Developing capacity for enhanced rates or incentives for integrated care by providers;	P/P provider initiatives	Full			
6.36.9.1.12	Providing or arranging for training of MCO providers and Care Managers on identification and screening of behavioral health conditions and referral procedures;	Training materials Provider handbook	Full			
6.36.9.1.13	Conducting Case Management rounds at least monthly with the Behavioral Health Case Management team; and	CM rounds minutes/schedule	Full			
6.36.9.1.14	Participating in regular collaborative meetings at least yearly or as needed, with LDH representatives for the purpose of coordination and communication.	Meeting minutes	Full			
6.40						
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH	P/P for CM	Full			

Core Benefits and Services						
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	for approval within thirty (30) days from the date the Contract is signed by the MCO, annually and prior to any revisions. Case Management policies and procedures shall include, at a minimum, the following elements:					
6.40.1	A process to offer voluntary participation in the Case Management Program to eligible members;	P/P for CM	Full			
6.40.2	Identification criteria, process, and triggers for referral and admission into the Case Management Program;	P/P for CM	Full			
6.40.3	Identification criteria, process, and triggers for referral and admission into a Perinatal Case Management Program which should include, but not be limited to, the following: .1 Reproductive aged women with a history of prior poor birth outcomes; and .2 High risk pregnant women.	P/P for CM	Full			
6.40.4	The provision of an individual needs assessment and diagnostic assessment; the development of an individual plan of care and treatment plan, as necessary, based on the needs assessment; the establishment of short and long term treatment objectives; the monitoring of outcomes; and a process to ensure that treatment care plans are revised as necessary. These procedures shall be designed to accommodate the specific cultural and linguistic needs of the MCO's members; Procedures must describe collaboration processes with member's treatment providers;	P/P for CM Treatment plan template	Full			
6.40.5	A strategy to ensure that all members and/or authorized family members or	P/P for CM	Full			

Core Benefits and Services						
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	guardians are involved in treatment care planning;					
6.40.6	Procedures and criteria for making referrals to specialists and subspecialists;	P/P for CM	Full			
6.40.7	Procedures and criteria for maintaining care plans and referral services when the member changes PCPs and behavioral health providers; and	P/P for CM	Full			
6.40.8	Coordination of Case Management activities for members also receiving services through the MCO's Chronic Care Management Program.	P/P for CM	Full			
6.41						
6.41	The MCO shall submit case management reports monthly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60) days prior to due date of those reports. The case management reports shall include at a minimum:	Evidence of Communication to LDH P/P CM	Full			
6.41.1	Number of members identified with potential special healthcare needs utilizing historical claims data;	CM/Special health Care needs reports	Full			
6.41.2	Number of members with potential special healthcare needs identified by the member's PCP and/or behavioral health provider;	CM/Special health Care needs reports	Full			
6.41.3	Number of members identified with potential special healthcare needs that self- refer;	CM/Special health Care needs reports	Full			
6.41.4	Number of members with potential special healthcare needs identified by the MCO;	CM/Special health Care needs reports	Full			
6.41.5	Number of members in the lock-in program;	CM/Special health Care needs reports	Full			
6.41.6	Number of members identified with	CM/Special health Care	Full			

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	special healthcare needs by the PASRR Level II authority;	needs reports				
6.41.7	Number of members with assessments completed, and	CM/Special health Care needs reports	Full			
6.41.8	Number of members with assessments resulting in a referral for Case Management.	CM/Special health Care needs reports	Full			
6.42						
6.42.1	The MCO shall provide a Chronic Care Management Program (CCMP) for members diagnosed with the following chronic conditions: Asthma; Congestive heart failure; Diabetes; HIV; Hepatitis C; Obesity; and Sickle Cell Anemia, particularly diagnosed members who are high utilizers of ED and inpatient services.	P/P for CCMP CCMP descriptions	Full			
6.42.3	The MCO shall also include one of the following chronic conditions in the CCMP for its members: hypertension as a precursor to coronary artery disease and stroke; chronic obstructive pulmonary disease (COPD), low back pain and chronic pain. Additional chronic conditions may be added at the MCO's discretion. The MCO shall include additional discretionary chronic conditions in CCMP reports, as delineated for required chronic conditions in the CCMP, to LDH.	P/P for CCMP CCMP descriptions	Full			
6.42.4	The MCO shall submit Chronic Care Management Program policies and procedures to LDH for approval within thirty (30) days of signing the Contract, annually and previous to any revisions. The MCO shall develop and implement policies and procedures that:	P/P for CCMP CCMP descriptions	Full			
6.42.4.1	Include the definition of the target population;	P/P for CCMP CCMP descriptions	Full			

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6.42.4.2	Include member identification strategies, i.e. through encounter data;	P/P for CCMP CCMP descriptions	Full			
6.42.4.3	Include evidence-based clinical guidelines that have been formally adopted by the QA/PI committee;	P/P for CCMP CCMP descriptions	Full			
6.42.4.4	Include guidelines for treatment plan development, as described in NCQA Disease Management program content, that provide the outline for all program activities and interventions;	P/P for CCMP CCMP descriptions	Full			
6.42.4.5	Include a written description of the stratification levels for each chronic condition, including member criteria and associated interventions;	P/P for CCMP CCMP descriptions	Full			
6.42.4.6	Include methods for informing and educating members and providers;	P/P for CCMP CCMP descriptions	Full			
6.42.4.7	Emphasize exacerbation and complication prevention utilizing evidence- based clinical practice guidelines and patient empowerment and activation strategies;	P/P for CCMP CCMP descriptions	Full			
6.42.4.8	Address co-morbidities through a whole-person approach;	P/P for CCMP CCMP descriptions	Full			
6.42.4.9	Identify members who require in-person case management services and a plan to meet this need;	P/P for CCMP CCMP descriptions	Full			
6.42.4.10	Coordinate CCMP activities for members also identified in the Case Management Program; and	P/P for CCMP CCMP descriptions	Full			
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions	Full			
6.44						
6.44.1	The MCO shall submit Chronic Care Management reports quarterly to LDH. LDH reserves the right to request additional reports as deemed necessary. LDH will notify the MCO of additional required reports no less than sixty (60)	Communications to LDH	Not Applicable This requirement is addressed in the Case Management – LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care			

Core Benefits and Services						
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	days prior to due date of those reports.		Management Program (CCMP) Summary on 5/16/2018.			
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports	Full			
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports	Not Applicable This requirement is addressed in the Case Management– LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on 5/16/2018.			
6.44.2.3	Number of members who were disenrolled from program and explanation as to why they were disenrolled.	CCMC reports	Not Applicable This requirement is addressed in the Case Management– LA Policy and Procedure on page 11 and the FW Change to Making Medicaid Better email documents that LDH retired the quarterly Chronic Care Management Program (CCMP) Summary on 5/16/2018.			
6.44.3 6.44.3.1	The MCO shall submit the following report annually: Chronic Care Management Program evaluation.	CCMC reports	Full			
6.45	**Services for Co-occurring Behavioral Health and Developmental Disabilities**					
6.45.1	The MCO shall create a framework for delivery of services, staff development, and policies and procedures for providing effective care for members with co-occurring behavioral health and developmental disabilities. This population should have the same reasonable access to behavioral health services as someone without a co-occurring behavioral health and developmental disability. If a member qualifies for services through OCDD, the	Care Management Policy		Full	This requirement is addressed in policy Case Management - LA	

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	MCO shall coordinate with OCDD, LGEs, and support coordinators concerning the care of the member. A Statement of Approval from OCDD shall not preclude services from the MCO.					
6.46	**Applied Behavior Analysis (ABA)**					
	Effective February 1, 2018, the MCO shall cover Applied Behavior Analysis (ABA) services.	Statement of Covered Benefits		Full	This requirement is addressed in policy Case Management - LA	
	The MCO shall coordinate and ensure continuity of care between behavioral health specialists, primary care physicians, and other health care specialists, including but not limited to providers qualified to perform Comprehensive Diagnostic Evaluations (CDE), occupational therapists, physical therapists, and speech therapists as indicated and based on medical necessity criteria for such services.	Care Management Policy		Full	This requirement is addressed in policy Case Management - LA	
	The MCO shall ensure member and provider call center staff and utilization management staff are knowledgeable in ABA services. Staff shall be capable of providing an explanation of ABA services, a list of ABA providers, and information regarding the prior authorization process to members or providers seeking information.	Care Management Policy Training Policy UM Policy and Procedures		Full	This requirement is addressed in policy Case Management - LA	
	ABA service shall not be denied solely because a member does not have an Autism Spectrum Disorder (ASD) diagnosis.	Statement of Covered Benefits		Full	This requirement is addressed in policy Case Management - LA	