United Healthcare

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

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

List of Tables

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 in full compliance in the full 2019 annual compliance audit were reviewed.

This report presents IPRO's findings of the 2020 annual compliance audit for United Healthcare (UHC).

Audit Overview

The purpose of the audit was to assess UHC'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 United Healthcare's policies, procedures, files, and other materials corresponding to the following seven contractual domains:

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

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 area:

1. 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
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 UHC 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 14, 2020, file reviews that were considered less than fully compliant based upon review were discussed. In the second session on August 28, 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	3	3	0	0	0	0	100%
Provider Network Requirements	18	8	10	0	0	0	44%
Utilization Management	2	2	0	0	0	0	100%
Fraud, Waste and Abuse	2	2	0	0	0	0	100%
Core Benefits and Services	13	7	6	0	0	0	54%
Reporting	1	1	0	0	0	0	100%
Total	**41**	**25**	**16**	**0**	**0**	**0**	**61%**

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

As presented in **Table 3**, 41 elements were reviewed for compliance. Of the 41 elements, 25 were determined to fully meet the regulations, while 16 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 61% 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 UHC 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 2020 Audit Elements

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
6.16	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	Substantial	This requirement is addressed in the UnitedHealthcare Community Plan Provider Manual on pages 49, 59 and 60; however, there was no policy document to support this requirement and the Member Handbook did not inform the member of this specific benefit. <u>Recommendation</u> The MCO is advised to develop a sterilization policy that translates regulations 42 CFR §441.250 - 441.259 into policy and procedure language, and to clarify sterilization benefit coverage language in the Member Handbook.	UHC is drafting a policy addressing sterilization which will be submitted to LDH via the Act 319 process once internal approvals are completed.
6.19	Services for Special Populations					
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	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review	Substantial This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure. <u>File Review Results</u> Of the 10 case management files, 9 had an individual care plan based on the needs assessment, and 9 of 10	Substantial	This requirement is addressed in the Chronic Illness Program Process Policy and Procedure, the Intensive Opportunity Program Management Policy and Procedure, and the Case Management Process	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1

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
	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 be:		care plans included short- and long-term care goals. Of the 8 applicable files (excluding 2 with multiple unsuccessful outreach attempts), 8 plans of care were developed with member and/or family involvement. Of the 10 behavioral health case management files, the requirement for a care plan was applicable to 9 cases (excluding 1 PASRR case). Of the 9 applicable cases, 8 had a care plan based upon the member's individual needs assessment that was developed with the involvement of the member/family, and that included short- and long-term member goals. Nine (9) of 9 applicable files (excluding 1 PASRR case) included a care plan that documented member demographics and supports and services. Of the 8 files with documented indication for crisis planning, 8 met this requirement. <u>Recommendation</u> The MCO should encourage clinical case managers to tailor the plan of care to the member's individual needs beyond those identified by the member in the initial needs assessment. <u>MCO Response:</u> 1. The Plan will educate our staff on EQRO audit recommendations.		Policy and Procedure. <u>File Review Results</u> Of the 10 case management files reviewed, 10 met the requirement for involvement of member/family in treatment care planning. Seven (7) of 10 files had an individual care plan based on the needs assessment, and 6 of these 7 files had care plans that also included short and long term goals. Of the 10 behavioral health case management files, 7 met the requirement for an individual care plan based on the needs assessment and 7 of these 7 files met the requirement for member/family involvement. Of these same 7 files, 6 met the requirement to include member goals. Five (5) of the 10 files reviewed had a plan for addressing crisis to prevent unnecessary	meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan

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
			2. The case management team will take the approach of being more specific in the care plan, including notations within the care plan under each O.G.I. (Opportunity, Goals, and Interventions) specific to the member's needs regardless of whether it applies to resources or disease specific processes. 3. The case management team will document updated findings within the member's plan of care. All notes will reflect information and updates through the period of member's enrollment. Final Review Determination: No change in determination. The plan agreed to the recommendation moving forward.		hospitalization. Recommendation The MCO should deploy quality improvement tools such as process flow diagrams to identify barriers to care plan development and implementation consistent with the policies for the Chronic Illness Program Process, the WPC Model, the Intensive Opportunity Program Management policy, and the Case Management Process policy and procedures. Examples of barriers to consider include whether staff assignments are appropriate in terms of clinical knowledge required and whether current systems of communication and documentation are sufficient to ensure continuity and comprehensiveness of care. Based upon the discussion at the interview, the MCO should also explore opportunities to integrate the BH	for addressing barriers is in progress.

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
					Advocate/Medical Director treatment planning process with the Case Management Comprehensive Needs Assessment process in order to generate a care plan.	
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 is addressed for Medicaid, CHIP, dual Special Needs Plans (DSNP), and Medicare/Medicaid Program (MMP) plans in the NCM 002 High-Risk Case Management Process Policy and Procedure. <u>File Review Results</u> The requirement for ongoing care plan review was applicable to 6 case management files (4 were excluded due to lack of sufficient timeframe for care plan follow-up or multiple unsuccessful outreach attempts. Six (6) of 6 files met the requirement for ongoing care plan review. Monitoring of outcomes and revision of the treatment plan as necessary was documented in either the care plan or care coordination notes for 7 of the 7 applicable cases (excluding 3 without sufficient timeframes). Of the 8 applicable behavioral health case management files7 documented monitoring of outcomes. Of the 7 applicable behavioral health case management files, 6 documented	Substantial	This requirement is addressed in the Case Management Policy and Procedure. <u>File Review Results</u> Ten (10) of 10 files case management files reviewed met the requirement for monitoring of outcomes, and 8 of 10 met the requirement for revision of the treatment plan as necessary. Of the 10 behavioral health case management files reviewed, 5 met the requirements for monitoring of outcomes and revision of treatment plan as necessary. <u>Recommendation</u> The MCO should ensure that care plans are used to monitor and communicate member	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in

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
			revision of the care plan as necessary. <u>Recommendations</u> The MCO should ensure that care plans are used to monitor and communicate member outcomes, with revisions made as indicated and communicated to behavioral health and physical health care managers and providers. The MCO should enhance case management interventions for the IET PIP. <u>MCO Response:</u> The plan will educate our staff on the EQRO audit recommendations. <u>Final Review Determination</u>: No change in determination. The plan agreed to the recommendation moving forward.		outcomes, with revisions made as indicated and communicated to behavioral health and physical health care managers and providers.	development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.
6.28	Care Management					
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	Substantial This requirement is addressed in the NCM 006 Integration of Physical and BH Care Policy and Procedure, in the CS_WPC_Chronic Illness_Prgrm Management Procedure document, , in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description, and the Member Handbook for Integrated Health Services; however, it is not clear how this requirement is met for members with physical health or behavioral health benefits, only, per documentation in the Member Handbook for Physical Health	Substantial	This requirement is addressed in the Member Handbook for Integrated Health Services on page 44, as well as in the Member Handbook For Physical Health Services on page 46. The Member Handbook For Mental Health and Substance Use Treatment Services does not address this requirement; however, the MCO explained at the interview that this	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and

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
			Services and in the Member Handbook for Mental Health and Substance Use Treatment. <u>File Review Results</u> Of the 9 applicable case management files (excluding 1 with multiple unsuccessful contacts), 9 contained documentation that prevention and treatment services are accessible and comprehensive. Of the 8 applicable case management files (excluding an additional member without indications for referral), 8 met the requirement for referrals as indicated. Of the 8 applicable behavioral health case management files, 8 met the requirement for recording the member's PCP in the care management record or otherwise follow-up. <u>Recommendation</u> The MCO should revise the member handbooks for members with either one physical or behavioral health benefits only to explain to members that they are entitled to care coordination and how to access that care coordination. The MCO should improve behavioral case management to ensure that all members have access to comprehensive prevention and treatment services.		requirement does not apply to the Medicare/Medicaid dual eligible members who receive this handbook. <u>File Review Results</u> Of the ten (10) case management files reviewed, 9 met the requirement for accessible and comprehensive treatment services and 9 met the requirement for referrals made as necessary. Of the ten (10) behavioral health case management files reviewed, 6 met the requirements for care coordination and for referrals as needed. <u>Recommendation</u> The MCO should deploy quality improvement tools such as process flow diagrams to identify barriers to care coordination consistent with the policies for the Chronic Illness Program Process, the WPC Model, the Intensive	annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.

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
			Final Review Determination: No change in determination. There was no MCO Response and Plan of Action..		Opportunity Program Management policy, and the Case Management Process policy and procedures. The focus should be on behavioral health case management cases, although enhanced processes should be applicable to all members in case management. Examples of barriers to consider include whether staff assignments are appropriate in terms of clinical knowledge required and whether current systems of communication and documentation are sufficient to ensure continuity and comprehensiveness of care.	
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical	CM records P/P for care coordination Includes Care Management File Review	Substantial This requirement is addressed in the CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure, CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure, and CS_WPC_Intensive Opportunity_Prgrm Mgmt Policy and Procedure, as well as in the entitled 2018 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care	Substantial	This requirement is addressed in the Chronic Illness Program Policy and Procedure, the Intensive Opportunity Program Management Policy and Procedure, and the Case Management Process Policy and Procedure. File Review Results	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days.

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
	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.		on page 28. <u>File Review Results</u> Of the 10 case management files reviewed, 8 met the requirement for ongoing care coordination, although initial coordination of activities with the Chronic Care Management Program was documented for 10 of 10 files. Five (5) of 7 files with behavioral health conditions received behavioral health care coordination. Eight (8) of 8 applicable files met the requirement for referrals made when necessary. Of the 10 behavioral health case management files, 9 of the 9 applicable files met the requirement for ongoing care coordination, as well as the requirements for coordination of activities with the Chronic Care Management Program as applicable, and for referrals when necessary. Contact was made with the Integrated Medicaid Managed Care Program plan care manager for 10 of 10 files. <u>Recommendations</u> The MCO should improve overall care coordination by increasing the involvement of clinical (i.e., RN) care managers (CMs) in order to supplement nonclinical community outreach workers' successful contacts with active member engagement in CM, with communication to local		Of the ten (10) case management files reviewed, 10 met the requirement for care coordination, as well as coordination of activities with the Chronic Care Management Program. Of the ten (10) behavioral health case management files reviewed, coordination of activities with the Chronic Care Management program was applicable to 8 files, and 5 of the 8 files met this requirement. <u>Recommendation</u> The MCO should deploy quality improvement tools such as process flow diagrams to clarify how the staff roles, activities and communications of the Chronic Care Management program dovetail with all other care management programs. The focus should be on behavioral health case management cases, although	*Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.

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
			MCO staff in a comprehensive care coordination policy and procedure that is applicable to all members. In addition, the MCO should encourage greater involvement of clinical CMs to tailor the POC to members' individual needs beyond those identified by the member and programmed by the CM software based upon the initial health assessment. The MCO should encourage enhanced clinical CM interaction with to improve POC monitoring and revision by enhancing continuity of clinical care across multiple CM episodes. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care. <u>Final Review Determination:</u> No change in determination. The plan agreed to the recommendation moving forward.		enhanced processes should be applicable to all members in case management. The MCO is also advised to identify communication, documentation and resultant are gaps between the Chronic Care Management program and all other care management programs.	
6.30	Care Coordination, Continuity of Care, and Care Transition					
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	Substantial This requirement is addressed in the UHC_CS_WPC_Program Description, and in the Member Handbook on pages 13 and 14. <u>File Review Results</u> Of the 10 case management files	Full	This requirement is addressed in the Whole Person Centered Care Model (WPC) Policy and Procedure, in the Member Handbook for Physical Health Services on page 16, and in the	

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
			reviewed, this requirement was applicable to 9 (excluding 1 file that documented multiple unsuccessful outreach attempts to contact the member). Of the 9 applicable files, 9 met this requirement. Of the 10 behavioral health case management files reviewed, this requirement was applicable to 8, with 7 of 8 files meeting the requirement for an ongoing source of preventive and primary care; however, release of information from the member/family was obtained to coordinate care with the PCP and other healthcare providers for 8 of 8 applicable files. <u>Recommendation</u> The MCO should improve BH follow-up case management to ensure ongoing access to and receipt of comprehensive preventive care. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care. <u>Final Review Determination</u>: No change in determination. The plan agreed to the recommendation moving forward.		Member Handbook for Integrated Health Services on page 15. The Member Handbook For Mental Health and Substance Use Treatment Services does not address this requirement; however, the MCO explained at the Interview that this requirement does not apply to the Medicare/Medicaid dual eligible members who receive this handbook. <u>File Review Results</u> Ten (10) off the 10 case management files reviewed met this requirement. Ten (10) of the 10 behavioral health case management files reviewed met this requirement.	
6.30.2.11	Coordinate hospital	P/P for care	Substantial	Substantial	This requirement is	UHC is currently addressing

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
	and/or institutional discharge planning that includes post-discharge care as appropriate, including 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:	coordination Includes Care Management File Review	This requirement is addressed in the Discharge Planning Policy, the RX-046 Automated Transition of Care Policy and Procedure, in the CS_WPC_Transitions of Care Policy and Procedure, and in the Coordination of BH Care Policy and Procedure. <u>File Review Results</u> Of the 10 case management files reviewed, 10 met this requirement. Of the 10 behavioral case management files reviewed, there were 8 applicable files (i.e., members with a hospitalization). Of these 8, 5 met the discharge planning requirement. <u>Recommendation</u> The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO should address this opportunity in the IET PIP, as well as more broadly for the behavioral health population. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. UM includes case management in their bi-weekly meeting. UM care		addressed in the Whole Person Centered Care Model (WPC) Policy and Procedure. <u>File Review Results</u> This requirement was applicable to eight (8) of the 10 case management files reviewed. Seven (7) of the applicable files met this requirement. This requirement was applicable to five (5) of the 10 behavioral health case management files. None (0) of the 5 applicable files met this requirement. <u>Recommendation</u> The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO is also advised to investigate improvements to system notifications to facilitate early identification, documentation and	member management system alerts for discharge notifications to address discharge planning coordination.

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
			advocates are prompted to include case management when involvement is beneficial for the member -- this has been in place since approximately May 2019. 3. Discharge planning from an interdisciplinary perspective is in place - including inpatient case management, utilization management, and case management. The UM team begins the discharge plan at the time of admission. After reviewing the facility's discharge plan, the UM team can make recommendations if they identify gaps/issues/concerns with the member. High needs members are being identified through a specific report and addressed in this interdisciplinary process. UM engages in discharge discussions at the beginning of the member's inpatient stay. 4. Training for the case managers was completed July 8th. The training included: • CHW scope of practice o Individuals with a SUD need a referral to a BHA to address SUD component of gaps in care o Referrals and resources related to SUD or other BH needs are best addressed by BHA • Team opportunities field visits o CHWs, RNs, and BHAs can conduct		communication of member hospitalizations. The MCO should address this opportunity in the IET/FUA PIP, as well as more broadly for the behavioral health population.	

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
			a collaborative field visit in any member's home (especially members with BH needs or SUD) o Leverage technology when possible (Web-ex for virtual visit if BHA not in area/ Chris, Karen and Shelby will need Web-ex access) • Provider access o Live and Work Well for Virtual BH visits • MAT (medication assistance therapy) providers o Medical providers are able to provide MAT • Peer support education o Currently 1 internal PSS to support all of Louisiana (time is split ½ PSS and ½ PSH) o Possible resources for external peer support specialist teams 5. Quality is working with the Community Healthcare Workers to support through education on how to provide members with information when SUD or BH issues are present. <u>Final Review Determination</u>: No change in determination. The plan agreed to the recommendation moving forward, with several actions implemented during the current period, although after the review period.			
7.3						
7.3.0	The MCO shall comply with the following	Network Provider Development and	Substantial This requirement is partially	Substantial	This requirement is addressed by individual	Submitted with previous audit deliverables on

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
	maximum 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 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.	Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	addressed in the Network Provider Development Management on pages 4 to 8. <u>Recommendation</u> The MCO should incorporate the new contract language in the Network Provider Development Management Plan. Specifically, the MCO should replace "as determined by LDH approved mapping software" with "as specified in the Provider Network Companion Guide." <u>MCO Response:</u> UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.		elements of section 7.3.	7/30/2020. Our Network Provider Development Management Plan was updated and reads: "7.3 Geographic Access Requirements In building our provider network, we will comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. We understand that requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests will include data on the local provider population available to the non-Medicaid population."
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers Travel distance for members living in rural parishes shall not exceed 30 miles; and Travel distance for	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for	Substantial This requirement is addressed in the Network Provider Development Management on page 4. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance.	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are

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
	members living in urban parishes shall not exceed 10 miles	exceptions	The MCO's Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for PCPs, but all rural parishes meet the access standards for both adult and pediatric PCPs. <u>Recommendation</u> The MCO should improve access to PCPs for their urban members. <u>MCO Response:</u> UHC Networks Division will continue its efforts to improve access to PCP's for members located in urban parishes. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		all urban parishes. <u>Recommendation</u> The MCO should improve access to PCPs for members in urban parishes.	pursued.
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Adequacy standards for distance are mostly met for rural parishes. Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for hospitals. <u>MCO Response:</u> Currently there are no hospitals located within Tensas Parish. All	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all urban parishes. The state is considering whether it is appropriate to modify its contract requirements.	

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
			hospitals in neighboring parishes of Franklin, Madison, and Concordia are contracted with UCCCP. The nearest in-network hospital is located within 32 miles of Tensas parish.			
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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is partially addressed in the Network Provider Development Management Plan on page 5. Currently, it states, "Travel distance to each specialty type shall not exceed 15 miles and 30 minutes." This is more restrictive than what is listed in the requirement; however, the Q1 2019 Report and a Q4 2018 Gap Analysis Report show evidence that the MCO addresses the requirement language. Approximately 95% or better of members have access to each of the listed specialists within 60 miles of residence. All members are within 60 miles of an Ophthalmologist or Otorhinolaryngology specialist. <u>Recommendation</u> The MCO should update the language in the Network Development Plan regarding access to specialists. <u>MCO Response:</u> UHC will update the Network Development Management Plan to include the specific requirements related to OB/GYN providers as defined in the in the LDH Network	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance requirements were not met for: dermatology (exceeded 90 miles) endocrinology and metabolism (exceeded 90 miles) <u>Recommendation</u> The MCO should improve access to dermatology and endocrinology specialties.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued.

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
	MCO's telemedicine utilization must be approved by LDH for this purpose.		Companion guide.			
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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Most of rural region members are within distance to a lab, but only 45% of members in Tensas Parish have access to a lab within the standards listed. Most of urban region members are within distance to a lab, but only 57% of members in Ouachita Parish have access to a lab within the standards listed. <u>Recommendation</u> The MCO should improve access to lab services for all rural and urban members. <u>MCO Response:</u> UHC Networks Division will continue its efforts to improve access to labs for all members with a heightened focus on the parishes of Tensas and Ouachita. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements were not met for lab and radiology services in urban parishes. <u>Recommendation</u> The MCO should improve access to lab and radiology services in urban parishes.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 our analysis indicated no providers available to resolve any gaps to the standards in lab and radiology, however we continually review this and all gaps for improvement.
7.3.5	Pharmacies	Network Provider	Substantial	Substantial	This requirement is	UHC continually monitors

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
7.3.5.1 7.3.5.2	Travel distance shall not exceed 10 miles in urban parishes; and Travel distance shall not exceed 30 miles in rural parishes.	Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	This requirement is addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The access standards are met for rural regions. Most but not all urban regions meet the access standards for pharmacy services. <u>Recommendation</u> The MCO should improve access to pharmacy services for all urban members. <u>MCO Response:</u> UHC Networks Division will continue its efforts to improve access to pharmacy services for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		addressed in 220 UHC 2019 SA2. Distance and/or time requirements were not met for pharmacies in urban parishes. <u>Recommendation</u> The MCO should improve access to pharmacies in urban parishes.	Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued.
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers Travel distance shall not exceed 10 miles in urban areas; and 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 as proof of compliance. The access standards are met for most rural regions. Some urban regions meet the access standard for pharmacy.	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements were met for hemodialysis centers in rural parishes but not urban parishes. <u>Recommendation</u> The MCO should improve	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 our analysis indicated no providers available to resolve any gaps to the standards in hemodialysis, however we

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 The MCO should improve access to pharmacy services for all rural and urban members. MCO Response: UHC Networks Division will continue its efforts to improve access to hemodialysis centers for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		access to hemodialysis centers in urban parishes.	continually review this and all gaps for improvement.
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	Substantial This requirement is partially addressed in the Q1 2019 220 Report. Region 6 does not meet ratio standards for allergy, dermatology and endocrinology, specialists. Region 5 does not meet the ratio standard for dermatology, and Region 8 does not meet the standard ratio requirement for endocrinology. Recommendation The MCO should recruit enough specialists to meet the ratio standards for specialists across all regions of Louisiana. MCO Response: UHC Networks Division will continue its efforts to increase the number of specialists within the regions that do not currently meet the standard ratio requirement. UHC monitors the	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Provider to Member Ratio requirements were not met for allergy/immunology, dermatology, and endocrinology and metabolism. Recommendation The MCO should improve provider to member ratios for allergy/immunology, dermatology, and endocrinology and metabolism.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 there were no additional Allergy/Immunology providers in Region 6 available to add to our network. There are additional Dermatology and Endocrinology providers identified in Region 5 we are evaluating for network recruitment/contracting, UHC will continue its efforts to increase the number of specialists within the regions that do not currently meet

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
			quarterly Contracted Provider data report for increases and decreases in provider subsets by location.			the standard ratio requirement where providers are available for contracting.
7.8.14	Specialized Behavioral Health Providers					
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,	P/P provider network P/P care coordination Network reports	Substantial This requirement is not met as discussed on the 348 Report on Crisis Stabilization for Q1 2019; the MCO do not have crisis specialist type providers in their network. However, the MCO is currently addressing this gap in provider coverage by researching opportunities within their provider network to opening this level of care in the community. The MCO mentioned they have one signed letter of intent with Start Corporation to operate the Safe Haven Center when it opens in St. Tammany. At UHC's suggestion, the 5 MCOs in LA are collaborating to strategize on developing the CS network for youth and adults. Single case agreements and transportation reimbursements are discussed in the Provider Network Development Plan. <u>Recommendation</u> The MCO should continue with their efforts to ensure members have access to crisis stabilization providers and seek to expand or grow this provider type within their provider network. <u>MCO Response:</u>	Substantial	This requirement was addressed during the onsite interview. The MCE reports that there are no licensed crisis stabilization providers in Louisiana. The MCO has taken the following steps to address this requirement: Possible recruitment for crisis stabilization December 2020 MCO has expanded network, with the approval of the Louisiana Department of Health, to offer an "in lieu of service" with MH IOP. MCO has expanded network, with the approval of the Louisiana Department of Health, to offer an "In lieu of service" with peer support services	UHC will continue to outreach new providers and work to ensure contract with Recovery Innovations when the unit opens in the Baton Rouge Area.

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
	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 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		UHC will continue to reach out to providers to expand levels of care and collaborate with LDH and fellow MCOs to expand the network as possible. Opportunities to expand care with crisis centers and community based alternatives to emergency room use will continue. Provider availability for Emergent and Urgent situations are monitored quarterly as part of the 359 report to ensure availability exceeds the threshold of 90%.		<u>Recommendation</u> The recommendation remains unchanged from the prior review. The MCO should continue with their efforts to ensure members have access to crisis stabilization providers and seek to expand or grow this provider type within their provider network.	

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
	reimbursed through the MCO, including meals and lodging as appropriate.					
7.8.15	Indian Health Care providers (IHCPs)					
7.8.15.1	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	Substantial This requirement is addressed in the Network Development Plan. The MCO contracts with all sorts of provider types. However, the MCO noted in a follow-up response to the audit that the only Indian Health Clinic approved by the state has refused to join their network. However, members may seek care at this clinic and the clinic is reimbursed at the state-assigned encounter rate for all covered services. The MCO noted that the printed provider directory informs members of the provider's Native American status; however, the example provided is not evidence of a provider as an IHCP. The provider example the MCO pointed out is a doctor of Indian (from India) origin, not Native American. In review of the online provider directory, one cannot identify Native American Providers. <u>Recommendation</u> The MCO should try to enroll IHCPs and Indian Health Clinics into their provider network, and ensure that their Native American membership can find access to IHCPs in the	Substantial	This requirement is addressed in the UHCCP LA Network Provider Development Management Plan with BH January 2020. The MCO reports that Indian Health Care Providers whether in or out of network are paid for covered services. However, this information is not communicated to members in the member handbook. <u>Recommendation</u> The MCO should communicate to members (e.g. in the member handbook) that out of network Indian health care providers are covered as if they are in network.	We have updated our Member Handbook to include this information. The following statement is found under the heading of Indian Health Services on page 24 of our Member Handbook, "American Indian Members are able to receive covered health care services from any Indian Health Service provider or tribally owned and/or operated facility at any time.

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
			provider directory online. <u>MCO Response:</u> UHC Networks Division will continue its recruiting efforts with Indian Health Clinics. Provider ethnicity that is captured within the UHC Online Provider Directory is a self-reported field. UHC will work with its provider network to encourage the submission of demographic data needed to assist Native American membership with locating the physician of their choice.			

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**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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.	Policy 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;	Policy for Member Disenrollment	Substantial This requirement is addressed in the disenrollment policy. The first two bullets are not addressed in the member handbooks. Post-onsite, a member newsletter and integrated welcome letter included language on member rights, and makes reference to member services should members need assistance in addressing concerns. **Recommendation** The MCO should incorporate the	Full	This requirement is addressed on page 64 of the member handbook.	

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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.		language of the contract into the member handbook so that members are directly informed of their disenrollment rights. <u>MCO Response:</u> This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.			
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).	Policy for Member Disenrollment	Full			
11.11.3.3	The member (or his/ her representative) must submit an oral or written formal request to the Enrollment Broker for disenrollment.	Policy for Member Disenrollment	Substantial This requirement is addressed in the disenrollment policy. Members are encouraged to call the Enrollment Broker, whose number is listed in all three handbooks. However, there is no explicit reference to this as the	Full	This requirement is addressed on page 64 of member handbook.	

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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**
			Enrollment Broker's contact number. Members should be directly informed that is who they need to reach out to with disenrollment requests. **<u>Recommendation</u>** The MCO should update the written language in the handbook(s) to state that members (or their representative) must contact the Enrollment Broker, and the number listed in the book is in reference to the Broker. <u>MCO Response:</u> This was recently added in the Member Handbooks. State approved the revisions on 8/13/2019.			
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.	Policy 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	Policy for Member Disenrollment Member Notification Letter	Full			

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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 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)).					
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.	Policy for Member Disenrollment	Full			
11.11.4.3	The MCO may request involuntary disenrollment of a member if the member 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;	Policy for Member Disenrollment	Full			
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.	Policy 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	Policy for Member Disenrollment	Full			

Eligibility, Enrollment and Disenrollment						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.56)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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**
	(See Appendix T).					
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.	Policy 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.	Policy for Member Disenrollment	Full			
11.11.4.8	The Enrollment Broker debwill provide written 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.	Policy 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.	Policy 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.	Policy 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	Policy 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 Policy for Disclosure of Financial Interest				
12.9.5	All written materials must be in accordance with the LDH "Person First" Policy, Appendix NN.	Policy for Written Member Materials Guidelines Policy 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.	Policy 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.	Policy 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;	Policy for Written Member Materials Guidelines Policy 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.	Policy 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	Policy for Written Member Materials Guidelines Policy for Informing	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**
	developmental disabilities. These alternatives must be provided at no expense to the member.	Members/Potential Members 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.	Policy for Member Education Policy for Member Disenrollment Policy for Member Enrollment Policy 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	Brochures and other examples of literature including EPSTD	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**
	charts, regarding all health or wellness promotion programs offered by the MCO's Medicaid Managed Care Plan. This would also include, but not be limited to, EPSDT outreach materials and member appointment and preventive testing reminders;	materials				
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 Policy for 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.	Policy for member education	Full			
12.12	**MCO Member Handbook**					
12.12.1	The MCO shall develop and maintain separate member handbooks that adhere	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**
	to the requirements in 42 CFR §438.10 (g) and may use the state developed model 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	Full			
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	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**
	health benefits and information about health education and promotion programs, 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	Substantial This requirement is partially addressed through the member handbook. The MCO provided a screenshot of a Member and Provider Call Centers via screen via their Benefit Matrix showing it is available through both in and out of network. However, an explanation should be included that explains the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. **Recommendation** The MCO should include information in the member handbook explaining that the MCO cannot require the enrollee to obtain a referral before choosing family planning provider. MCO Response: This was recently revised in the Member Handbooks. State	Full	This requirement is addressed on page 33 of UHC's member handbook.	

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**
			approved the revisions on 7/25/2019.			
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 forth in 42 CFR 422.113(c);	Member Handbook	Full			
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	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**
	provided by the MCO if the member objects (or in the case of a child, if the parent or guardian objects)on religious grounds;					
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: The right to a hearing; The method for obtaining a hearing; and 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; 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: Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and The member may be required to pay the cost of services furnished while the 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**
	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 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.	Member Handbook	Full			
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	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**
	residence, or mailing address changes;					
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 sponsored insurance. Such situations shall be reported the MCO;	Member Handbook	Full			
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	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**
	instruction shall be included in all versions of the handbook in English and Spanish ;					
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 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,	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**
	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 website and advises the member in paper or electronic form that the information is available at the specified web address; or		Full			
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	Dated revision of 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**
	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.	handbook				
12.14	**Provider Directory for Members**					
12.14.1	The MCO shall develop and maintain a Provider Directory in four (4) formats:	Policy for Provider Directory Provider Directory	Full			
12.14.1.1	A hard copy directory, when requested, for members and potential members;	Policy 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;	Policy for Provider Directory Provider Directory (website link)	Substantial This requirement is partially addressed through the web URL that was submitted for the provider directory. A web-based machine-readable version is not available. **<u>Recommendation</u>** The MCO should make available a web-based machine-readable version. <u>MCO Response:</u> UHC has initiated Accessibility procedures for new documents (like Member Handbooks) or document updates. The Plan will have all web-based machine readable content available by 12/31/19.	Full	This requirement is addressed in the screenshots provided by UHC.	
12.14.1.3	Electronic file of the directory to be submitted and updated weekly to the Medicaid FI, the Enrollment Broker, or other designee as determined by LDH; for the Enrollment Broker; and	Policy for Provider Directory Provider Directory (electronic file format)	Full			
12.14.1.4	Hard copy, abbreviated version upon	Policy 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**
	request by the Enrollment Broker.	Provider Directory (abbreviated hard copy)				
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.	Policy 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 office, and whether the provider has completed cultural competency training. The provider directory shall also indicate whether the provider's office/facility has	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Substantial This requirement is addressed in the hardcopy provider directory as well as the online version. However, website URLs and the provider's cultural competency training are not included. **<u>Recommendation</u>** The MCO should include both the website URL and the provider's cultural competency training in their directory. <u>MCO Response:</u>	Full	This requirement is addressed in the screenshots UHC 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**
	accommodations for people with physical disabilities, including offices, exam room(s) and equipment;		The Plan agrees and will include both the website URL and the provider's cultural competency training in the directory.			
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;	Policy 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	Policy for Provider Directory Provider Directory (full hard copy, website version, electronic file, abbreviated hard copy)	Full			
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).	Policy 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.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract	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 MCO shall further ensure that the MCO's employees, contractors and MCO providers consider and respect those rights when providing services to members.	Contractor Contract				
12.15.2	Members Rights. The rights afforded to current members are detailed in Appendix AA, Members' Bill of Rights.	Policy 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.	Policy for Member Rights and Responsibilities Member Handbook Provider Manual Provider Contract Contractor Contract	Full			
12.17.16.2	The MCO members' responsibilities shall 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;	Policy for Member Rights and Responsibilities 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**
	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.					
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 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.	Policy for Provider Termination Policy for notifying members of provider termination	Full			
12.18.2	The MCO shall provide notice to a member or the parent/legal guardian and the involved state agency, as appropriate,	Policy for Provider Termination Policy 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**
	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.					
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 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	Policy for oral and written interpretation services Policy for notification of member of interpretation services and how to access the 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**
	Spanish.					
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).	Policy for oral and written interpretation services Policy 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 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.	Policy for Member Rights and Responsibilities	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 access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid	P/P for Provider Network 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**
	members with physical or mental disabilities.					
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 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 disclose 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	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**
	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						
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	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**
	appointments shall be arranged within fourteen (14) days of referral;	Standards Provider Handbook/Manual Provider contracts Member Handbook				
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 Standards Provider Handbook/Manual Provider contracts Member Handbook	Full			
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	Full			
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	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 contracts Member Handbook				
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						
7.3.0	The MCO shall comply with the following maximum 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 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.	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is partially addressed in the Network Provider Development Management on pages 4 to 8. **<u>Recommendation</u>** The MCO should incorporate the new contract language in the Network Provider Development Management Plan. Specifically, the MCO should replace “as determined by LDH approved mapping software” with “as specified in the Provider Network Companion Guide.” <u>MCO Response:</u> UHC will update the Network Development Management Plan to include the specific time and	Substantial	This requirement is addressed by individual elements of section 7.3.	Submitted with previous audit deliverables on 7/30/2020. Our Network Provider Development Management Plan was updated and reads: "7.3 Geographic Access Requirements In building our provider network, we will comply with the following maximum travel time and/or distance requirements, as specified in the Provider Network Companion Guide. We understand that requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval. Such requests will include data on the local provider

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**
			distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.			population available to the non-Medicaid population."
7.3.1 7.3.1.1 7.3.1.2	Primary Care Providers Travel distance for members living in rural parishes shall not exceed 30 miles; and Travel distance for members living in urban parishes shall not exceed 10 miles	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is addressed in the Network Provider Development Management on page 4. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The MCO's Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for PCPs, but all rural parishes meet the access standards for both adult and pediatric PCPs. **Recommendation** The MCO should improve access to PCPs for their urban members. MCO Response: UHC Networks Division will continue its efforts to improve access to PCP's for members located in urban parishes. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.	Substantial	This requirement is addressed in 220 UHC 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 members in urban parishes.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued.

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**
7.3.2 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Adequacy standards for distance are mostly met for rural parishes. Q1 2019's Geo Access Report indicates that not all urban parishes meet the access standards for hospitals. <u>MCO Response:</u> Currently there are no hospitals located within Tensas Parish. All hospitals in neighboring parishes of Franklin, Madison, and Concordia are contracted with UCCCP. The nearest in-network hospital is located within 32 miles of Tensas parish.	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements are met for all rural parishes, but not all 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 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	Network Provider Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	Substantial This requirement is partially addressed in the Network Provider Development Management Plan on page 5. Currently, it states, "Travel distance to each specialty type shall not exceed 15 miles and 30 minutes." This is more restrictive than what is listed in the requirement;	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance requirements were not met for: dermatology (exceeded 90 miles) endocrinology and	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued.

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**
	utilize telemedicine to meet network adequacy requirements, the MCO's telemedicine utilization must be approved by LDH for this purpose.		however, the Q1 2019 Report and a Q4 2018 Gap Analysis Report show evidence that the MCO addresses the requirement language. Approximately 95% or better of members have access to each of the listed specialists within 60 miles of residence. All members are within 60 miles of an Ophthalmologist or Otorhinolaryngology specialist. **Recommendation** The MCO should update the language in the Network Development Plan regarding access to specialists. MCO Response: UHC will update the Network Development Management Plan to include the specific requirements related to OB/GYN providers as defined in the in the LDH Network Companion guide.		metabolism (exceeded 90 miles) **Recommendation** The MCO should improve access to dermatology and endocrinology 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. Most of rural region members	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements were not met for lab and radiology services in urban parishes.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 our analysis indicated no

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**
			are within distance to a lab, but only 45% of members in Tensas Parish have access to a lab within the standards listed. Most of urban region members are within distance to a lab, but only 57% of members in Ouachita Parish have access to a lab within the standards listed. **<u>Recommendation</u>** The MCO should improve access to lab services for all rural and urban members. <u>MCO Response:</u> UHC Networks Division will continue its efforts to improve access to labs for all members with a heightened focus on the parishes of Tensas and Ouachita. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		**<u>Recommendation</u>** The MCO should improve access to lab and radiology services in urban parishes.	providers available to resolve any gaps to the standards in lab and radiology, however we continually review this and all gaps for improvement.
7.3.5 7.3.5.1 7.3.5.2	Pharmacies Travel distance shall not exceed 10 miles in urban parishes; and 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 to show compliance. The access standards are met for rural regions. Most but not all urban regions meet the access	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements were not met for pharmacies in urban parishes. **<u>Recommendation</u>**	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued.

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 for pharmacy services. **<u>Recommendation</u>** The MCO should improve access to pharmacy services for all urban members. <u>MCO Response:</u> UHC Networks Division will continue its efforts to improve access to pharmacy services for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		The MCO should improve access to pharmacies in urban parishes.	
7.3.6 7.3.6.1 7.3.6.2	Hemodialysis Centers Travel distance shall not exceed 10 miles in urban areas; and 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 addressed in the Network Provider Development Management Plan on page 5. The MCO provided the Network Adequacy Report for Q1 2019 as proof of compliance. The access standards are met for most rural regions. Some urban regions meet the access standard for pharmacy. **<u>Recommendation</u>** The MCO should improve access to pharmacy services for all rural and urban members. <u>MCO Response:</u>	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Distance and/or time requirements were met for hemodialysis centers in rural parishes but not urban parishes. **<u>Recommendation</u>** The MCO should improve access to hemodialysis centers in urban parishes.	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 our analysis indicated no providers available to resolve any gaps to the standards in hemodialysis, however we continually review this and all gaps for improvement.

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**
			UHC Networks Division will continue its efforts to improve access to hemodialysis centers for all members. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.			
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	Substantial This requirement is partially addressed in the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least 90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH GeoAccess Report shows that 100% of members have access to BH specialists. **Recommendation** The MCO should update the access standard language on page 6 to address that access to BH specialists should not exceed the 30 miles or 60 minutes for 90% of rural members. MCO Response:	Full	This requirement is addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met for Specialized Behavioral Health Providers.	

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**
			UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.			
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 partially addressed in the Network Provider Development Management Plan on page 6, but reference to the access standard being met for at least 90% of members is missing. BH Geo Access Reports show monitoring of the requested specialists. The BH Provider Manual informs BH providers and facilities of the required standards for accessibility. The BH Geo Access Report shows that 100% of members have access to BH specialists. **<u>Recommendation</u>** The MCO should update the access standard language on page 6 to address that access to BH specialists should not exceed the 15 miles or 30 minutes for 90% of urban members. <u>MCO Response:</u> UHC will update the Network	Full	This requirement is addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met for Specialized Behavioral Health Providers in 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**
			Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.			
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 This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of members have access to Psychiatric inpatient hospitals. **<u>Recommendation</u>** The MCO should update the access standard language in the Network Development Plan to address that access to psych hospitals should not exceed the 90 miles or 90 minutes for 90% of members. <u>MCO Response:</u> UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.	Full	This requirement is addressed in 6 348 Geo Access Report Aril 2020 Q1. 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	Network Provider	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**
	miles or 60 minutes for 90% of adult members. Maximum time for admission or appointment shall not exceed 10 business days.	Development and Management Plan P/P for Access and Availability GeoAccess reports Requests for exceptions	This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and 99.8% of rural members have access to ASAM Level 3.3 providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members. MCO Response: UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.		addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met for ASAM Level 3.3.	
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	Substantial This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report.	Full	This requirement is addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met	

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**
			100% of urban members and 98.3% of rural members have access to ASAM Level 3.5 providers. **<u>Recommendation</u>** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 30 miles or 60 minutes for 90% of members. <u>MCO Response:</u> UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.		for ASAM Level 3.5.	
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	Substantial This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and rural members have access to ASAM Level 3.7 providers. **<u>Recommendation</u>**	Full	This requirement is addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met for ASAM Level 3.7.	

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 MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members. MCO Response: UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.			
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	Substantial This requirement is partially addressed in the Network Provider Development Management Plan, as well as in the 12182018 Appointment Availability Report. 100% of urban members and rural members have access to ASAM Level 3.7 WM providers. **Recommendation** The MCO should update the access standard language in the Network Development Plan to address that accessibility to the listed provider type should not exceed the 60 miles or 90 minutes for 90% of members.	Full	This requirement is addressed in 6_348 Geo Access Report Aril 2020 Q1. Distance and/or time requirements were met for ASAM Level 3.7 WM.	

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: UHC will update the Network Development Management Plan to include the specific time and distance requirements allowed for each provider specialty as defined in the in the LDH Network Companion guide.			
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			
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	Substantial This requirement is partially addressed in the Q1 2019 220 Report. Region 6 does not meet ratio standards for allergy, dermatology and endocrinology, specialists. Region 5 does not meet the ratio standard for	Substantial	This requirement is addressed in 220 UHC 2019 SA2. Provider to Member Ratio requirements were not met for Allergy/immunology,	UHC continually monitors Network Adequacy and Accessibility which are static by nature. Monthly reviews are done and opportunities to close gaps with additional provider contracts are pursued. As of 9/16/20 there

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**
			dermatology, and Region 8 does not meet the standard ratio requirement for endocrinology. **Recommendation** The MCO should recruit enough specialists to meet the ratio standards for specialists across all regions of Louisiana. MCO Response: UHC Networks Division will continue its efforts to increase the number of specialists within the regions that do not currently meet the standard ratio requirement. UHC monitors the quarterly Contracted Provider data report for increases and decreases in provider subsets by location.		dermatology, and endocrinology and metabolism. **Recommendation** The MCO should improve provider to member ratios for allergy/immunology, dermatology, and endocrinology and metabolism.	were no additional Allergy/Immunology providers in Region 6 available to add to our network. There are additional Dermatology and Endocrinology providers identified in Region 5 we are evaluating for network recruitment/contracting, UHC will continue its efforts to increase the number of specialists within the regions that do not currently meet the standard ratio requirement where providers are available for contracting.
7.5						
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				

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**
7.5.2 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 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.	GeoAccess reports Communication to LDH/ attestation				
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				
7.6						
7.6.1	**Provider Participation -**	Provider contracts Network Provider Development and Management Plan P/P for Provider Network				
7.6.1.6	The MCO must offer a Contract to the following providers: Louisiana Office of Public Health (OPH);	Network Provider Development and	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**
	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 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).	Management Plan P/P for Provider Network				
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 reached and a STP does	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**
	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			
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	Network Provider Development and	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**
	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.	Management Plan P/P for Provider Network P/P for Provider Credentialing P/P for Provider Selection and Retention				
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: Revocation of the provider's home and community-based services license or behavioral health service license; Exclusion from the Medicaid program; Termination from the Medicaid program; Withholding of Medicaid reimbursement as authorized by the Department's Surveillance and utilization Review (SURS) Rule (LAC 50:I.Chapter 41); 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 The Louisiana Attorney General's Office has seized the assets of the service provider.	P/P for Provider Network	Full			
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	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**
	(50) states, the District of Columbia, and any U.S. territories.					
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 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	Full			
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			

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**
7.6.3.6	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	Full			
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 UnitedHealthcare Credentialing Plan 2019-2021 and credentialing committee meeting minutes.	
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	Full			
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	Full			
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	Provider contracts 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
	different time from that provided to other members, other public or private patients, or the public at large.					
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 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	P/P provider contracts Provider Contract Provider Handbook	Full			
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	P/P for PCP Responsibilities	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 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;	Provider Handbook/Manual Provider contracts				
7.8.2.6	Development of plan of care to address risks and medical needs and other responsibilities as defined in Section 6.33.	P/P for PCP Responsibilities Provider Handbook/Manual Provider contracts	Full			
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					

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**
	specified in this Section in regard to timeliness and service area.					
7.8.3.2	The MCO provider network shall include participating specialists with pediatric expertise for children/adolescents when the need for pediatric specialty care is significantly different from the need for adult specialty care (*e.g.* a pediatric cardiologist).	P/P for Provider Network P/P for Access to Specialty Providers GeoAccess reports	Full			
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	Full			
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	P/P for Provider Network P/P for Access to Specialty	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
	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.	Providers P/P for direct access services				
7.8.4 7.8.4.1	**Hospitals** Hospital services providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations and adhere to the requirements set forth in this RFP.					
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: 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. 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	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**
	tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day. 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-network Medicaid enrolled	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**
	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 RHCs (both freestanding and hospital-based) in the state.	P/P for Provider Network Contracts with FQHC/RHCs	Full			
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.					

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**
7.8.11.2	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 (LGEs) for the provision of Medicaid services.	P/P provider network P/P care coordination Network reports	Full			
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		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**
	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.					
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			
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	P/P provider network P/P care coordination Network reports	Substantial This requirement is not met as discussed on the 348 Report on	Substantial	This requirement was addressed during the onsite interview. The	UHC will continue to outreach new providers and work to ensure contract with Recovery

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**
	(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 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.		Crisis Stabilization for Q1 2019; the MCO do not have crisis specialist type providers in their network. However, the MCO is currently addressing this gap in provider coverage by researching opportunities within their provider network to opening this level of care in the community. The MCO mentioned they have one signed letter of intent with Start Corporation to operate the Safe Haven Center when it opens in St. Tammany. At UHC's suggestion, the 5 MCOs in LA are collaborating to strategize on developing the CS network for youth and adults. Single case agreements and transportation reimbursements are discussed in the Provider Network Development Plan. **<u>Recommendation</u>** The MCO should continue with their efforts to ensure members have access to crisis stabilization providers and seek to expand or grow this provider type within their provider network. <u>MCO Response:</u> UHC will continue to reach out to providers to expand levels of care and collaborate with LDH		MCE reports that there are no licensed crisis stabilization providers in Louisiana. The MCO has taken the following steps to address this requirement: Possible recruitment for crisis stabilization December 2020 MCO has expanded network, with the approval of the Louisiana Department of Health, to offer an "in lieu of service" with MH IOP. MCO has expanded network, with the approval of the Louisiana Department of Health, to offer an "In lieu of service" with peer support services **<u>Recommendation</u>** The recommendation remains unchanged from the prior review. The MCO should continue with their efforts to ensure members have	Innovations when the unit opens in the Baton Rouge Area.

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 fellow MCOs to expand the network as possible. Opportunities to expand care with crisis centers and community based alternatives to emergency room use will continue. Provider availability for Emergent and Urgent situations are monitored quarterly as part of the 359 report to ensure availability exceeds the threshold of 90%.		access to crisis stabilization providers and seek to expand or grow this provider type within their provider network.	
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	Substantial This requirement is addressed in the Network Development Plan. The MCO contracts with all sorts of provider types. However, the MCO noted in a follow-up response to the audit that the only Indian Health Clinic approved by the state has refused to join their network. However, members may seek	Substantial	This requirement is addressed in the UHCCP LA Network Provider Development Management Plan with BH January 2020. The MCO reports that Indian Health Care Providers whether in or out of network are paid	We have updated our Member Handbook to include this information. The following statement is found under the heading of Indian Health Services on page 24 of our Member Handbook, "American Indian Members are able to receive covered health care services from any Indian Health Service provider

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**
			care at this clinic and the clinic is reimbursed at the state-assigned encounter rate for all covered services. The MCO noted that the printed provider directory informs members of the provider's Native American status; however, the example provided is not evidence of a provider as an IHCP. The provider example the MCO pointed out is a doctor of Indian (from India) origin, not Native American. In review of the online provider directory, one cannot identify Native American Providers. **Recommendation** The MCO should try to enroll IHCPs and Indian Health Clinics into their provider network, and ensure that their Native American membership can find access to IHCPs in the provider directory online. MCO Response: UHC Networks Division will continue its recruiting efforts with Indian Health Clinics. Provider ethnicity that is captured within the UHC Online Provider Directory is a self-reported field. UHC will work		for covered services. However, this information is not communicated to members in the member handbook. **Recommendation** The MCO should communicate to members (e.g. in the member handbook) that out of network Indian health care providers are covered as if they are in network.	or tribally owned and/or operated facility at any time.

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**
			with its provider network to encourage the submission of demographic data needed to assist Native American membership with locating the physician of their choice.			
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 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: Indian members are permitted by the MCO to access out-of-state IHCPs; or If this circumstance is deemed to be good cause for	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**
	disenrollment from the State's Managed Care Program in accordance with 42 CFR §438.56(c).					
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						
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	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**
	the location provides physical access for Medicaid enrollees with disabilities.					
7.9.2	The Network Provider Development and Management Plan shall demonstrate access to Services and Benefits as defined in this RFP, access standards in 42 CFR §438.206 and shall include:	Provider Network Development and Management Plan	Full			
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 ,	Provider Network Development and	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**
	Special Conditions for Prenatal Providers, Second Opinion Out-of-Network Providers	Management Plan				
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 of LDH and the MCO, including compliance with all policies	P/P for Network Development and	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 procedures related to the grievance/appeal processes and ensuring the member's care is not compromised during the grievance/appeal processes;	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 and any needed revisions, shall be submitted to LDH at the end of the first year of	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**
	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 services, including providers of specialized services (e.g., DD population, sexual offending behaviors, and early childhood development);	Network development Implementation plan P/P provider network	Full			
	GEO mapping and coding of all specialized behavioral health network providers for each specialized behavioral health provider type to geographically demonstrate	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**
	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;					
	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: Current and anticipated numbers of Title XIX and Title XXI eligibles; and 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: The number of current qualified specialized 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; The geographic location of specialized behavioral health providers and members considering distance, travel time, and available means of transportation; Availability of specialized behavioral health services and appointments with physical access for persons with disabilities; and Any service access standards detailed in a SPA or waiver.	Network development Implementation plan P/P provider network	Full			
7.9.8.3	The MCO shall submit to LDH as part of its annual Network	Evidence of submission of	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**
	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 arbitration data; and Issues, concerns and requests identified by other state agency personnel, local agencies and community stakeholders.	network development Plan to LDH Network and development plan				
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;	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**
	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.					
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 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.	Network development and management plan	Full			
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	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**
	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 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						
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	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**
	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, 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	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**
	alternatives that will be used to fill them.					
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: 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 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:	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**
	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. 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 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.	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**
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						
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 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).	P/P for Coordination with Other Service Providers	Full			
7.13						
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						
7.14.1	The MCO must have a written credentialing and re-credentialing process that complies with 42 CFR §438.12,	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**
	§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.					
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 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:	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**
	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 Includes Credentialing/Recredentialing File Review	Full			
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	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 Directory				
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 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.	P/P for credentialing & recredentialing	Full			
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	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**
	of applicable board certification.					
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 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.	P/P for credentialing & 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	Full			
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						
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	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 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:	Provider Handbook/Manual Provider contracts				
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 Provider Handbook/Manual Provider contracts	Full			
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			

Utilization Management

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.1	**General Requirements**					
8.1.1	The MCO shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization.	P/P for UM Evidence of timely submission of P/P for UM	Full			
8.1.2	The UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:					
8.1.2.1	Are adopted in consultation with contracting health care professionals;	P/P for UM	Full			
8.1.2.2	Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;	P/P for UM	Full			
8.1.2.3	Are considerate of the needs of the members; and	P/P for UM	Full			
8.1.2.4	Are reviewed annually and updated periodically as appropriate.	P/P for UM	Full			
8.1.3	The policies and procedures shall include, but not be limited to:					
8.1.3.1	The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;	P/P for UM	Full			
8.1.3.2	The data sources and clinical review criteria used in decision making;	P/P for UM	Full			
8.1.3.3	The appropriateness of clinical review shall be fully documented;	P/P for UM	Full			
8.1.3.4	The process for conducting informal reconsiderations for adverse determinations;	P/P for UM	Full			
8.1.3.5	Mechanisms to ensure consistent application of review criteria and compatible decisions;	P/P for UM	Full			
8.1.3.6	Data collection processes and analytical methods used in assessing utilization of health care services;	P/P for UM	Full			
8.1.3.7	Provisions for assuring confidentiality of clinical and proprietary information;	P/P for UM	Full			
8.1.3.8	Service authorization criteria for specialized behavioral	P/P for UM	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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 services that are consistent with the Medicaid State Plan;	P/P Coordination of services				
8.1.3.9	Collaborating with OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;	P/P for UM P/P Coordination of services	Full			
8.1.3.10	Collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;	P/P for UM P/P Coordination of services	Full			
8.1.3.11	Collaborating with the Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers; and	P/P for UM P/P Coordination of services	Full			
8.1.3.12	Collaborating with nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.	P/P for UM P/P Coordination of services	Full			
8.1.4	The MCO shall coordinate the development of clinical practice guidelines with other LDH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs.	P/P for UM P/P for guideline development coordination P/P for guideline research, selection, adoption, review, update, & update schedule Sample adopted guidelines	Full			
8.1.5	The MCO shall disseminate the practice guidelines to all	P/P for UM	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	affected providers and, upon request, to members and potential members.	P/P for guideline dissemination Sample adopted guidelines				
8.1.5.1	The MCO shall take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on MCO measurement findings. The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance.	Provider contracts Compliance reports	Substantial This requirement is partially addressed in the Clinical Practice Guidelines and the Provider Manual. UHC provided reports documenting the tracking of the rates. However, they were not achieving the 80% compliance rate. **Recommendation** The MCO should employ substantive provider motivational incentive strategies, such as financial and non-financial incentives, to improve compliance. MCO Response: The health plan agrees with the recommendation. The health plan will promote the use of Clinical Practice Guidelines with incentives to improve compliance to 90% or higher.	Full	This requirement is addressed in the LA UHC CP Medicaid Utilization Management Policy – Table 3A and the report Behavioral Health8_358 UHC 2020 Q2_BH.	
8.1.6	The MCO must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:	P/P for UM P/P for medical management criteria	Full			
8.1.6.1	The vendor must be identified if the criteria was purchased;	P/P for UMP/P for medical management criteria	Full			
8.1.6.2	The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;	P/P for UM P/P for medical management criteria	Full			
8.1.6.3	The guideline source must be identified if the criteria are based on national best practice guidelines; and	P/P for UM P/P for medical management criteria	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.1.6.4	The individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.	P/P for UM P/P for medical management criteria	Full			
8.1.7	UM Program medical management criteria and practice guidelines shall be posted to the MCO's website. If the MCO uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, the MCO may post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, the MCO must provide the specific criteria and practice guidelines utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.	P/P for UM P/P for guideline dissemination	Full			
8.1.8	The MCO shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures shall be given verbally to the covered person or health care provider when requested. The procedures shall outline the process to be followed in the event the MCO determines the need for additional information not initially requested.	P/P for UM P/P for required information P/P for additional information	Full			
8.1.9	The MCO shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, the MCO may deny authorization of the requested service(s) within two (2) business days.	P/P for UM	Full			
8.1.10 8.1.10.1 8.1.10.2	The MCO shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. The MCO	P/P for UM Staffing plan	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	shall provide UM staff specifically assigned to: Specialized behavioral health services, and PSH to ensure appropriate authorization of tenancy services.					
8.1.11	The MCO shall use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition.	P/P for UM	Full			
8.1.13	The MCO must identify the qualification of staff who will determine medical necessity.	P/P for UM Staffing plan	Full			
8.1.14	Determinations of medical necessity must be made by qualified and trained practitioners in accordance with state and federal regulations.	P/P for UM	Full			
8.1.15	The MCO shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.	P/P for UM Includes UM File Review	Full			
8.1.16	The individual(s) making these determinations shall have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.	P/P for UM	Full			
8.1.17	The individual making these determinations is required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise.	P/P for UM	Full			
8.1.18	The MCO shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be sufficient in an amount, duration, and	P/P for UM	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. The MCO shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. The MCO may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.					
8.1.21	The MCO shall ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210.	P/P for UM	Full			
8.4	**Service Authorization**					
8.4.1	Service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.	P/P for UM P/P for service authorization	Full			
8.4.2	The MCO UM Program policies and procedures shall include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of *Chisholm v. Gee and Wells v. Gee* for initial and continuing authorization of services that include, but are not limited to, the following:	P/P for UM P/P for service authorization	Full			
8.4.2.1	Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or	P/P for UM P/P for service authorization	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	does not request a service in a timely manner;					
8.4.2.2	Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;	P/P for UM P/P for service authorization	Full			
8.4.2.3	Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease;	P/P for UM P/P for service authorization	Full			
8.4.2.4	Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process shall be included in its member manual and incorporated in the grievance procedures;	P/P for UM P/P for service authorization	Full			
8.4.2.5	The MCO's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers; and	P/P for UM P/P for service authorization	Full			
8.4.2.6	The MCO's service authorization system shall have capacity to electronically store and report the time and date all service authorization requests are received, decisions made by the MCO regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.	P/P for UM P/P for service authorization	Full			
8.4.3	The MCO shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the MCO can provide the service through an in-network or out-of-network provider for a lower level of care.	P/P for UM P/P for service authorization	Full			
8.4.4	Not later than July 1, 2018, the MCO shall utilize a common hospital observation policy that is developed and maintained collectively by MCO personnel with approval of LDH. The common hospital observation policy	P/P prior authorization P/P for UM	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	shall be reviewed annually by the MCOs in its entirety. Any revisions shall be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.					
8.4.5	The MCO shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state or state mental hospitals.	P/P prior authorization P/P for UM	Full			
8.4.5.1	The MCO shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. The MCO shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].	P/P for UM	Full			
8.4.5.2	Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.	P/P for UM	Full			
8.4.5.3	Concurrent utilization review includes: Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not	P/P for UM Evidence of timely submissions Notification communication to member/provider	Full			

Utilization Management						
Contract Reference	Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)	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 hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from the MCO for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour after request is received by an emergency room for post- stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized. Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from the MCO for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours after the referral and full medical information is received by MCO. The screen to determine appropriate treatment shall be completed within 24 hours of the MCO's referral after the referral and full medical information is received by MCO. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a					

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	child/youth, the procedures specified above should be utilized. Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, the MCO shall notify the provider and individual requesting the screen of the results in writing within 48 hours of receipt of the request by the MCO. If denied, the MCO shall notify the individual requesting the screen immediately, and within 48 hours of receipt of the request by the MCO provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.					
8.4.6	Certification of Need (CON) for PRTFs					
8.4.6.1	The MCO shall comply with the requirements set forth at 42 CFR §441 Subpart D.					
8.4.6.2	The MCO shall ensure LMHPs are included in the team responsible for certification and recertification of PRTF services in Louisiana. This shall include a face-to-face assessment by an LMHP or a telephonic/video consultation with an LMHP who has had a face-to- face interview with the child/youth, in addition to the recommendations of a team specified at 42 CFR §441.154.	P/P Service utilization P/P Certification/recertification	Full			
8.4.6.3	The MCO may use an LMHP/team composed of the MCO's staff or the MCO may subcontract with an LMHP. To ensure the team has knowledge of the ambulatory resources available to the youth and the youth's situation, the MCO shall ensure that the team is assembled by a subcontract in the child's/youth's parish of residence or adjacent parish (if not in state custody) or the child's/youth's parish or adjacent parish of responsibility (if in state custody).	P/P for UM LMHP Subcontract	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.4.6.4	Recertification shall occur every sixty (60) calendar days. For the PRTF screens to be complete, the team shall meet and rule out other community based options. This does not apply to other inpatient screens.	P/P certification	Full			
8.4.6.5	In addition to certifying the need, the MCO shall: Be responsible for tracking the member's authorization period for PRTF stays and providing notification to the responsible party when a recertification is due. Ensure that PRTF certification, including the independent certification, are forwarded to the admitting facility. Upon completion of the screen, if the PRTF is approved, within 48 hours the MCO shall notify in writing the provider requesting the certification of the results, the member/guardian and, with member guardian consent, the referring party requesting the PRTF services on behalf of the youth. If approved, the MCO shall, in consultation with the member's guardian and referring party, locate a PRTF provider appropriate to meet the member's needs with availability to admit the member. If denied, the MCO shall notify the provider requesting the certification immediately and within 48 hours provide written notification to the provider requesting the certification of the results, the member/guardian and, with the member/guardian consent, the referring party requesting the PRTF services on behalf of the youth. The notification shall include: information on alternative community services that may meet the member's needs to ensure health and safety, including information on available providers of those services, the right of the member to appeal, and the process to do so. For youth pending release from a secure setting for whom a PRTF is being requested, the MCO is required to coordinate the completion of the screen and the CON prior to the youth's release if it is anticipated that the youth will be re-linked to the MCO following release. Generate a prior authorization for each PRTF admission	P/P certification Tracking report P/P for UM Hospital reports	Substantial This requirement is partially addressed in the Standard Operating Procedure Certification/Recertification of PRTF services. However, the new contract language is not included. **Recommendation** The MCO should incorporate the new contract language into the standard operating procedure. MCO Response: The plan agrees and has updated its document to include the contractual language in this section.	Full	This requirement is addressed in the Standard Operating Procedure Certification/Recertification of PRTF services.	

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	within 48 hours of completion of the screen. Accurately determine admissions and discharges to PRTFs and perform PRTF-specific eligibility functions. Work with the Medicaid FI to determine retroactive eligibility and assignment, when applicable. Maintain near real time bed utilization/availability and manage a waiting list for PRTF placement including out-of-state replacements.					
8.5	**Timing of Service Authorization Decisions**					
8.5.1	**Standard Service Authorization**					
8.5.1.1	The MCO shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	P/P for UM P/P for standard service authorization	Full			
8.5.1.1.1 8.5.1.1.1.1 8.5.1.1.1.2	The service authorization decision may be extended up to fourteen (14) additional calendar days if: The member, or the provider, requests the extension; or The MCO justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.		Full			
8.5.1.2	The MCO shall make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.	P/P for UM P/P for concurrent review determinations	Full			
8.5.2	**Expedited Service Authorization**					

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.5.2.1	In the event a provider indicates, or the MCO determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.	P/P for UM P/P for expedited service authorization	Full			
8.5.2.2	The MCO may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the member or if the MCO justifies to LDH a need for additional information and how the extension is in the member's best interest.	P/P for UM P/P for post authorization	Full			
8.5.3	**Post Authorization**					
8.5.3.1	The MCO shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.	P/P for UM P/P for post authorization	Full			
8.5.3.2	The MCO shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.	P/P for UM P/P for post authorization	Full			
8.5.4	**Timing of Notice**					
8.5.4.1	**Notice of Action**					
8.5.4.1.1	**Approval [Notice of Action]**					
8.5.4.1.1.1	For service authorization approval for a non-emergency admission, procedure or service, the MCO shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall	P/P for UM P/P for notice timing Includes UM File Review	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.					
8.5.4.1.1.2	For service authorization approval for extended stay or additional services, the MCO shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing	Full			
8.5..4.1.2	**Adverse [Notice of Action]**					
8.5.4.1.2.1	The MCO shall notify the member, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in Section 13 of this RFP. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210 and Section 12 of this RFP for member written materials.	P/P for UM P/P for notice timing Includes UM File Review	Full			
8.5.4.1.2.2	The MCO shall notify the requesting provider of a decision to deny an authorization request or reauthorization or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The MCO shall notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.	P/P for UM P/P for notice timing Includes UM File Review	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.5.4.1.3	**Informal Reconsideration**					
8.5.4.1.3.1	As part of the MCO appeal procedures, the MCO should include an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.	P/P for UM P/P for informal reconsideration	Full			
8.5.4.1.3.2	In a case involving an initial determination or a concurrent review determination, the MCO should provide the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [(§438.402(b)(ii)].	P/P for UM P/P for informal reconsideration Includes UM File Review	Full			
8.5.4.1.3.3	The informal reconsideration should occur within one (1) working day of the receipt of the request and should be conducted between the provider rendering the service and the MCO's physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day.	P/P for UM P/P for informal reconsideration P/P for notice timing Includes Informal Consideration File Review	Full			
8.5.4.1.3.4	The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.	P/P for UM P/P for informal reconsideration P/P for notice timing	Full			
8.5.4.2	**Exceptions to Requirements**					
8.5.4.2	The MCO shall not require service authorization for emergency services or post-stabilization services as described in this Section whether provided by an in-network or out-of-network provider.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO shall not require service authorization or referral for EPSDT screening services.	P/P for UM P/P for exceptions	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
8.5.4.2	The MCO shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the MCO, regardless of whether such services are provided by an in-network or out-of-network provider, however, the MCO may require prior authorization of services beyond thirty (30) calendar days.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first 30 days of a newly enrolled member's linkage to the plan.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO shall not require a PCP referral for in-network eye care and vision services.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.	P/P for UM P/P for exceptions	Full			
8.5.4.2	The MCO may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.	P/P for UM P/P for exceptions	Full			
8.11	**Medical History Information**					
8.11.1	The MCO is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making medical necessity determinations.	P/P for UM	Full			
8.11.2	The MCO shall take appropriate action when a treating health care provider does not cooperate with providing	P/P for UM Provider	Full			

Utilization Management						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.210, 438.236, 438.420, 438.404)**	**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**
	complete medical history information within the requested timeframe.	Manual/Handbook Provider contracts				
8.11.3	Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, shall not be entitled to payment for the provision of such item or service.	P/P for UM Provider Manual/Handbook Provider contracts	Full			
8.11.4	Should a provider fail or refuse to respond to the MCO's request for medical record information, at the MCO's discretion or directive by LDH, the MCO shall, at a minimum, impose financial penalties against the provider as appropriate.	P/P for UM Provider Manual/Handbook Provider contracts	Full			
8.12	**PCP and Behavioral Health Provider Utilization and Quality Profiling**					
8.12.1	The MCO shall profile its PCPs and specialized behavioral health providers (including but not limited to addiction, mental health, and residential providers) and analyze utilization data to identify utilization and/or quality of care issues.	PCP/BN profiling report	Full			
8.12.2	The MCO shall investigate and intervene, as appropriate, when utilization and/or quality of care issues are identified.	P/P for UM	Full			
8.13	**Court-Ordered Assessment, Treatment, and Placement which Challenge Medical Necessity Determination and Defensible Lengths of Stay**					
8.13.1	All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by the MCO within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.	Evidence of timely submission of profile reports	Full			

Fraud, Waste and Abuse

Fraud, Waste and Abuse						
Contract 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.	FWA Compliance Plan	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	(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 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.					
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			

Fraud, Waste and Abuse						
Contract 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**
15.1.5	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	Full			
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 is not addressed in the FWA plan but is addressed by the recordkeeping section of the Community and State Appeals policy. The MCO provided their Grievance and Appeals Reports (112 and 113 Reports). **Recommendation** The MCO should include this language in the FWA Compliance Plan. MCO Response: This language was added to the FWA Compliance Plan and submitted to LDH in August 2019.	Full	This requirement is addressed in the FWA plan on page 17.	
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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.					
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	Full			
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	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms	Full			

Fraud, Waste and Abuse						
Contract 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**
	routine 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.					
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 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.	FWA Compliance Plan Network Provider Enrollment & Disclosure Forms Employee Disclosure Forms	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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.					
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 partially addressed in the FWA Compliance Plan. The MCO will confer with LDH prior to any recoupments. **Recommendation** The MCO should update the FWA compliance plan to address the conditions in which recoupments or withholds are prohibited when directed by LDH. MCO Response: The Plan has met this requirement in the SOP Prohibition to Recoup or Withhold document submitted under the FWA pre-onsite deliverables.	Full	This requirement is addressed in the FWA Compliance Plan on page 14.	
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	Full			
15.1.15.2	The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or	FWA Compliance Plan	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	investigation, or are being audited by the Louisiana RAC.					
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	Full			
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 Policy	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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
	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 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	Full			
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 Contract. The	FWA Compliance Plan Provider referral forms	Full			

Fraud, Waste and Abuse						
Contract 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 shall report suspected provider fraud using the LDH Provider Fraud Referral Form					
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	Full			
15.1.18.7.1	Contact the subject of the investigation about any matters related to the investigation;	FWA Compliance Plan	Full			
15.1.18.7.2	Enter into or attempt to negotiate any settlement or agreement regarding the incident; or	FWA Compliance Plan	Full			
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	Full			
15.1.18.8	The MCO shall promptly provide the results of its preliminary investigation to LDH or the agency to whom the incident	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	was reported, or to another agency designated by the agency that received the report.					
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	Full			
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.		Full			
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 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.	FWA Compliance Plan Provider Agreement Form	Full			

Fraud, Waste and Abuse						
Contract 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**
15.1.21	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,	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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 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.	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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 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:					
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			
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		Full			

Fraud, Waste and Abuse						
Contract 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
	auditing reported fraud, abuse, and waste in accordance with 42 CFR §438.608(b)(4-6);					
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 member's circumstance that may affect the member's eligibility including changes in the member's residence and death of a member.		Full			
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		Full			

Fraud, Waste and Abuse						
Contract 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
	corrective action initiatives related to the Contract in accordance with 42 CFR §438.608(b)(7);					
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 Integrity Officer and full-time program integrity investigator(s); and Provisions that comply with 42 CFR §438.608 and 438.610 and all relevant		Full			

Fraud, Waste and Abuse						
Contract 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**
	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					

Fraud, Waste and Abuse						
Contract 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
	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 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.	FWA Compliance Plan	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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 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	FWA Compliance	Full			

Fraud, Waste and Abuse						
Contract 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**
	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.	Plan				
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 of any money paid for services provided by an excluded provider.	FWA Compliance Plan	Full			
15.5						
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	Full			
15.5.2	The MCO shall notify LDH within three (3)	FWA Compliance	Full			

Fraud, Waste and Abuse						
Contract 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**
	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.	Plan				
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 Compliance Officer; and	FWA Compliance Plan	Full			
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,	FWA Compliance	Full			

Fraud, Waste and Abuse						
Contract 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**
	shall attest to LDH that a search of websites referenced in Section 15.3.3 has been completed to capture all exclusions.	Plan Attestation Form				
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						
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 MCO providers and contractors to maintain, an individual medical record for each member. The MCO shall ensure the medical record is:	Policy for medical records Policy for medical record documentation standards Policy for medical record monitoring Provider Manual Model Provider Contracts for all provider types	Full			
15.6.1.1	Accurate and legible;	Policy for medical records	Full			

Fraud, Waste and Abuse						
Contract 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
		Policy for medical record standards				
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	Policy for medical records Policy 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.	Policy for medical records Policy for medical record standards	Full			
15.6.2	The MCO shall ensure the medical record includes, minimally, the following:	Policy for medical records Policy 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);	Policy for medical records Policy for medical record standards	Full			
15.6.2.2	Primary language spoken by the member and any translation needs of the member;	Policy for medical records Policy for medical record standards	Full			
15.6.2.3	Services provided through the MCO, date of service, service site, and name of service provider;	Policy for medical records Policy for medical record standards	Full			
15.6.2.4	Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;	Policy for medical records Policy for medical record standards	Full			
15.6.2.5	Referrals including follow-up and outcome of referrals;	Policy for medical records Policy for medical	Full			

Fraud, Waste and Abuse						
Contract 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
		record standards				
15.6.2.6	Documentation of emergency and/or after-hours encounters and follow-up;	Policy for medical records Policy for medical record standards	Full			
15.6.2.7	Signed and dated consent forms (as applicable);	Policy for medical records Policy for medical record standards	Full			
15.6.2.8	Documentation of immunization status;	Policy for medical records Policy for medical record standards	Full			
15.6.2.9	Documentation of advance directives, as appropriate;	Policy for medical records Policy 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.	Policy for medical records Policy 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	Policy for medical records Policy for medical record standards	Full			

Fraud, Waste and Abuse						
Contract 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**
	screening; Appropriate 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.	Policy 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.	Policy for medical records Policy 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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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.					
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	Full			
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	Full			
15.7.5	Contact with the provider shall be	FWA Compliance	Full			

Fraud, Waste and Abuse						
Contract 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**
	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	Plan				
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 the provider any overpayments identified by LDH or its agent, and said recovered funds will be retained by the State.	FWA Compliance Plan	Full			
15.7.8	LDH shall not initiate its own review on the same claims for a network provider					

Fraud, Waste and Abuse						
Contract 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**
	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 response from the MCO within ten business days, the State may proceed with its review.	FWA Compliance Plan	Full			
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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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
	from the provider.					
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 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.	FWA Compliance Plan	Full			
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					

Fraud, Waste and Abuse						
Contract 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**
	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	Full			
	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 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.	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract 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**
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 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/	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract 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**
	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	Full			
17.2.6.1.9	**Provider Validation –**	FWA Compliance	Full			

Fraud, Waste and Abuse						
Contract 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**
	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	Plan				
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 Report 170 Ownership Disclosure	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 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)	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract 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**
	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. 18.3.3 If the MCO has operated previously in the commercial or Medicare	FWA Compliance Plan Provider Enrollment and Contract Forms	Full			

Fraud, Waste and Abuse						
Contract 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**
	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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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; 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	FWA Compliance Plan	Full			

Fraud, Waste and Abuse						
Contract 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**
	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).					
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 be used under the Assisted Suicide Funding Restriction Act of 1997; Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a state plan; and Any amount expended for home health care services unless the MCO provides the appropriate surety bond.	FWA Compliance Plan				

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	Minimal This requirement is addressed in the 6_4_10_Safe Haven LOI_Redacted Optum Letter of Intent to provide crisis stabilization services, dated January 29, 2019, but does not document availability of crisis intervention and stabilization services to members during the review period. The Member Handbook for Integrated Health Services includes a mental illness and addiction crisis line on page 3 and also includes a brief paragraph regarding crisis intervention as a service; however, there is an authorization requirement on page 50 documentation. **Recommendation:** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the MCO agreed to do so.	Full	This requirement is addressed in the Member Handbook for Integrated Health Services on page 52 and in the Member Handbook for Mental Health and Substance Use Treatment Services on page 28.	

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**
			MCO Response: This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019. **Final Review Determination**: No change in determination. The plan addressed the recommendation after the review period.			
6.8	**Emergency Medical Services and Post Stabilization Services**					
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 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.	Member handbook P/P ER services	Substantial This requirement is addressed in the UCSMM Policy 04 11 Consumer Safety Policy and in the Management of Behavioral Health Benefits Medicaid National (0219 Final) Policy and Procedure on page 3. The Member Handbook for Integrated Health Services indicates, on pages 21 and 22, that the member does not need a prior authorization for emergencies, with specific reference to mental health and substance use on page 42; however, the handbook also includes a brief paragraph on page 50 regarding crisis intervention as a service with an authorization requirement. **Recommendations:** The MCO should remove the PA requirement for crisis intervention as soon as possible from this and any other handbook that includes this PA requirement. On-site, the MCO agreed to do so.	Full	This requirement is addressed on pages 24 and 52 of the Member Handbook for Integrated Health Services, on page 28 of the Member Handbook for Mental Health and Substance Use Treatment Services, and on page 26 of the Member Handbook for Physical Health 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**
			MCO Response: This was recently revised in the Member Handbooks. State approved the revisions on 7/25/2019. **Final Review Determination**: No change in determination. The plan addressed the recommendation after the review period.			
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	P/P Coordination of services Communications to hospital	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**
	from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on the 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,	P./P Emergency services Member handbook	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**
	a prudent layperson is a person who possesses an average knowledge of health 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	P./P post stabilization services Provider handbook	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**
	network physician is reached or one of the criteria of (422.133(c)(3)) is met.					
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	Substantial	This requirement is addressed in the UnitedHealthcare Community Plan Provider Manual on pages 49, 59 and 60; however, there was no policy document to support this requirement and the Member Handbook did not inform the member of this specific benefit. **<u>Recommendation</u>** The MCO is advised to develop a sterilization policy that translates regulations 42 CFR §441.250 - 441.259 into policy and procedure language, and to clarify sterilization benefit coverage language in the Member Handbook.	UHC is drafting a policy addressing sterilization which will be submitted to LDH via the Act 319 process once internal approvals are completed.
6.19	**Services for Special Populations**					
6.19.1	Special Health Care Needs (SHCN) population is defined as individuals of any					

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
	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 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;					

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**
6.19.1.9	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 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.	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**
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: The MCO shall utilize Medicaid historical claims data (if available) to identify members who meet MCO, LDH approved, guidelines for SHCN criteria. MCO LMHPs and PCPs shall identify to the MCO those members who meet SHCN criteria. 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. 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 be:	P/P Individual Treatment Plans CM records Treatment &/or care plans Includes Case Management File Review	Substantial This requirement is addressed in the CS_WPC_LA_Care Management Process Policy and Procedure. **File Review Results** Of the 10 case management files, 9 had an individual care plan based on the needs assessment, and 9 of 10 care plans included short- and long-term care goals. Of the 8 applicable files (excluding 2 with multiple unsuccessful outreach attempts), 8 plans of care were developed with member and/or family involvement. Of the 10 behavioral health case management files, the requirement for a care plan was applicable to 9 cases	Substantial	This requirement is addressed in the Chronic Illness Program Process Policy and Procedure, the Intensive Opportunity Program Management Policy and Procedure, and the Case Management Process Policy and Procedure. **File Review Results** Of the 10 case management files reviewed, 10 met the requirement for involvement of member/family in treatment care planning. Seven (7) of 10 files had an individual care plan based on the needs assessment, and 6 of these 7 files had care plans that also included short and long term goals.	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and

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**
			(excluding 1 PASRR case). Of the 9 applicable cases, 8 had a care plan based upon the member's individual needs assessment that was developed with the involvement of the member/family, and that included short- and long-term member goals. Nine (9) of 9 applicable files (excluding 1 PASRR case) included a care plan that documented member demographics and supports and services. Of the 8 files with documented indication for crisis planning, 8 met this requirement. **Recommendation** The MCO should encourage clinical case managers to tailor the plan of care to the member's individual needs beyond those identified by the member in the initial needs assessment. MCO Response: 1. The Plan will educate our staff on EQRO audit recommendations. 2. The case management team will take the approach of being more specific in the care plan, including notations within the care plan under each O.G.I. (Opportunity, Goals, and Interventions) specific to the member's needs regardless of whether it applies to resources or disease specific processes. 3. The case management team will document updated findings within the member's plan of care. All notes will reflect information and updates through the period of member's enrollment. **Final Review Determination**:		Of the 10 behavioral health case management files, 7 met the requirement for an individual care plan based on the needs assessment and 7 of these 7 files met the requirement for member/family involvement. Of these same 7 files, 6 met the requirement to include member goals. Five (5) of the 10 files reviewed had a plan for addressing crisis to prevent unnecessary hospitalization. **Recommendation** The MCO should deploy quality improvement tools such as Process Flow diagrams to identify barriers to care plan development and implementation consistent with the policies for the Chronic Illness Program Process, the WPC Model, the Intensive Opportunity Program Management policy, and the Case Management Process policy and procedures. Examples of barriers to consider include whether staff assignments are appropriate in terms of clinical knowledge required and whether current systems of communication and documentation are sufficient to ensure continuity and comprehensiveness of care. Based upon the discussion at the interview, the MCO should also explore opportunities to integrate the BH Advocate/Medical Director treatment planning process with the	annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.

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**
			No change in determination. The plan agreed to the recommendation moving forward.		Case Management Comprehensive Needs Assessment process in order to generate a care plan.	
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 is addressed for Medicaid, CHIP, dual Special Needs Plans (DSNP), and Medicare/Medicaid Program (MMP) plans in the NCM 002 High-Risk Case Management Process Policy and Procedure. **File Review Results** The requirement for ongoing care plan review was applicable to 6 case management files (4 were excluded due to lack of sufficient timeframe for care plan follow-up or multiple unsuccessful outreach attempts. Six (6) of 6 files met the requirement for ongoing care plan review. Monitoring of outcomes and revision of the treatment plan as necessary was documented in either the care plan or care coordination notes for 7 of the 7 applicable cases (excluding 3 without	Substantial	This requirement is addressed in the Case Management Policy and Procedure. **<u>File Review Results</u>** Ten (10) of 10 files case management files reviewed met the requirement for monitoring of outcomes, and 8 of 10 met the requirement for revision of the treatment plan as necessary. Of the 10 behavioral health case management files reviewed, 5 met the requirements for monitoring of outcomes and revision of treatment plan as necessary. **<u>Recommendation</u>** The MCO should ensure that care plans are used to monitor and communicate member outcomes,	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter. Scheduled team meetings

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**
			sufficient timeframes). Of the 8 applicable behavioral health case management files7 documented monitoring of outcomes. Of the 7 applicable behavioral health case management files, 6 documented revision of the care plan as necessary. **Recommendations** The MCO should ensure that care plans are used to monitor and communicate member outcomes, with revisions made as indicated and communicated to behavioral health and physical health care managers and providers. The MCO should enhance case management interventions for the IET PIP. <u>MCO Response:</u> The plan will educate our staff on the EQRO audit recommendations. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.		with revisions made as indicated and communicated to behavioral health and physical health care managers and providers.	will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.
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 necessary services including specialized	P/P Individual Treatment Plans Plan of Care	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**
	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	Substantial This requirement is addressed in the NCM 006 Integration of Physical and BH Care Policy and Procedure, in the CS_WPC_Chronic Illness_Prgrm Management Procedure document, , in the WPC PD 2019 Whole Person Centered Care Model (WPC) Program Description, and the Member Handbook for Integrated Health Services; however, it is not clear how this requirement is met for members with physical health or behavioral health benefits, only, per documentation in the Member Handbook for Physical Health Services and in the Member Handbook for Mental Health and Substance Use Treatment. **File Review Results**	Substantial	This requirement is addressed in the Member Handbook for Integrated Health Services on page 44, as well as in the Member Handbook For Physical Health Services on page 46. The Member Handbook For Mental Health and Substance Use Treatment Services does not address this requirement; however, the MCO explained at the Interview that this requirement does not apply to the Medicare/Medicaid dual eligible members who receive this handbook. **File Review Results** Of the ten (10) case management files reviewed, 9 met the requirement for accessible and comprehensive treatment services	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter.

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**
			Of the 9 applicable case management files (excluding 1 with multiple unsuccessful contacts), 9 contained documentation that prevention and treatment services are accessible and comprehensive. Of the 8 applicable case management files (excluding an additional member without indications for referral), 8 met the requirement for referrals as indicated. Of the 8 applicable behavioral health case management files, 8 met the requirement for recording the member's PCP in the care management record or otherwise follow-up. **Recommendation** The MCO should revise the member handbooks for members with either one physical or behavioral health benefits only to explain to members that they are entitled to care coordination and how to access that care coordination. The MCO should improve behavioral case management to ensure that all members have access to comprehensive prevention and treatment services. **Final Review Determination**: No change in determination. There was no MCO Response and Plan of Action..		and 9 met the requirement for referrals made as necessary. Of the ten (10) behavioral health case management files reviewed, 6 met the requirements for care coordination and for referrals as needed. **Recommendation** The MCO should deploy quality improvement tools such as Process Flow diagrams to identify barriers to care coordination consistent with the policies for the Chronic Illness Program Process, the WPC Model, the Intensive Opportunity Program Management policy, and the Case Management Process policy and procedures. The focus should be on behavioral health case management cases, although enhanced processes should be applicable to all members in case management. Examples of barriers to consider include whether staff assignments are appropriate in terms of clinical knowledge required and whether current systems of communication and documentation are sufficient to ensure continuity and comprehensiveness of care.	Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.
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	P/P member Services Call center documentation	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**
	provision for reasonable and adequate hours of operation including 24 hour availability of information, referral, and treatment for emergency medical conditions; and					
6.28.2.3	Care coordination and referral activities, in person or telephonically depending on member's acuity, incorporate and identify appropriate methods of assessment and referral for members requiring both medical and behavioral health services. These activities must include scheduling assistance, monitoring and follow-up for member(s) requiring medical services and coordination for members requiring behavioral health services.	CM records P/P for care coordination Includes Care Management File Review	Substantial This requirement is addressed in the CS_WPC_Chronic Illness_Prgrm Mgmt Policy and Procedure, CS_PCCM_Med_Behavioral_Case Consult Policy and Procedure, and CS_WPC_Intensive Opportunity_Prgrm Mgmt Policy and Procedure, as well as in the entitled 2018 Annual Collaborative Analysis Continuity and Coordination between Behavioral Health and Medical Care on page 28. **File Review Results** Of the 10 case management files reviewed, 8 met the requirement for ongoing care coordination, although initial coordination of activities with the Chronic Care Management Program was documented for 10 of 10 files. Five (5) of 7 files with behavioral health conditions received behavioral health care coordination. Eight (8) of 8 applicable files met the requirement for referrals made when necessary. Of the 10 behavioral health case management files, 9 of the 9 applicable files met the requirement for ongoing care coordination, as well as the requirements for coordination of activities with the Chronic Care Management Program as applicable, and for referrals when necessary. Contact was made with the	Substantial	This requirement is addressed in the Chronic Illness Program Policy and Procedure, the Intensive Opportunity Program Management Policy and Procedure, and the Case Management Process Policy and Procedure. **File Review Results** Of the ten (10) case management files reviewed, 10 met the requirement for care coordination, as well as coordination of activities with the Chronic Care Management Program. Of the ten (10) behavioral health case management files reviewed, coordination of activities with the Chronic Care Management program was applicable to 8 files, and 5 of the 8 files met this requirement. **<u>Recommendation</u>** The MCO should deploy quality improvement tools such as Process Flow diagrams to clarify how the staff roles, activities and communications of the Chronic Care Management program dovetail with all other care management programs. The focus should be on	Each staff will undergo re-education through the following venues: *Each staff member will undergo an evaluation of their knowledge of care planning and the contractual components in their 1:1 meeting with their Manager in the next 30 days. *Each staff will participate in a Plan of Care training session to be scheduled in 4th Quarter 2020 and annually thereafter. Scheduled team meetings will be used to deep dive into the Plan of Care to allow staff the opportunity to fully understand the purpose and how to utilize this tool to drive practice. A comprehensive audit tool that incorporates all the compliance priorities is in development

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**
			Integrated Medicaid Managed Care Program plan care manager for 10 of 10 files. **Recommendations** The MCO should improve overall care coordination by increasing the involvement of clinical (i.e., RN) care managers (CMs) in order to supplement nonclinical community outreach workers' successful contacts with active member engagement in CM, with communication to local MCO staff in a comprehensive care coordination policy and procedure that is applicable to all members. In addition, the MCO should encourage greater involvement of clinical CMs to tailor the POC to members' individual needs beyond those identified by the member and programmed by the CM software based upon the initial health assessment. The MCO should encourage enhanced clinical CM interaction with to improve POC monitoring and revision by enhancing continuity of clinical care across multiple CM episodes. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.		behavioral health case management cases, although enhanced processes should be applicable to all members in case management. The MCO is also advised to identify communication, documentation and resultant are gaps between the Chronic Care Management program and all other care management programs.	Increased auditing will occur as follows: *Increase peer auditing *Increase self-audits *Each Manager will review staff audits for accuracy and compliance Peer Audit results will be shared with staff confidentially in their 1:1 meeting with their Manager. Development of Process Flow diagrams to identify and plan for addressing barriers is in progress.
6.28.2.4	Patients with a condition that causes	Pain management plans	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**
	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 UCSMM 04.11 Consumer Safety pg 4				
6.30	**Care Coordination, Continuity of Care, and Care Transition**					
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						
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**
	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	Substantial This requirement is addressed in the UHC_CS_WPC_Program Description, and in the member handbook on pages 13 and 14. **File Review Results**	Full	This requirement is addressed in the Whole Person Centered Care Model (WPC) Policy and Procedure, in the Member Handbook for Physical Health Services on page 16, and in the Member Handbook for Integrated Health Services on page	

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**
			Of the 10 case management files reviewed, this requirement was applicable to 9 (excluding 1 file that documented multiple unsuccessful outreach attempts to contact the member). Of the 9 applicable files, 9 met this requirement. Of the 10 behavioral health case management files reviewed, this requirement was applicable to 8, with 7 of 8 files meeting the requirement for an ongoing source of preventive and primary care; however, release of information from the member/family was obtained to coordinate care with the PCP and other healthcare providers for 8 of 8 applicable files. **Recommendation** The MCO should improve BH follow-up case management to ensure ongoing access to and receipt of comprehensive preventive care. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. There will be mandatory case consults to clinicians for integrated care. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward.		15. The Member Handbook For Mental Health and Substance Use Treatment Services does not address this requirement; however, the MCO explained at the Interview that this requirement does not apply to the Medicare/Medicaid dual eligible members who receive this handbook. **File Review Results** Ten (10) off the 10 case management files reviewed met this requirement. Ten (10) of the 10 behavioral health case management files reviewed met this requirement.	
6.30.2.3	Ensure each member is provided with information on how to contact the person designated to coordinate the services the member accesses;	P/P for care coordination Includes Care	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**
		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 aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and; assure that prior authorization for	P/P for care coordination Includes Care Management File Review	Substantial This requirement is addressed in the Discharge Planning Policy, the RX-046 Automated Transition of Care Policy and Procedure, in the CS_WPC_Transitions of Care Policy	Substantial	This requirement is addressed in the Whole Person Centered Care Model (WPC) Policy and Procedure. **File Review Results** This requirement was applicable to	UHC is currently addressing member management system alerts for discharge notifications to address discharge planning

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**
	prescription coverage is addressed and or initiated before patient discharge. The MCO must have policies and procedures requiring and assuring that:		and Procedure, and in the Coordination of BH Care Policy and Procedure. **File Review Results** Of the 10 case management files reviewed, 10 met this requirement. Of the 10 behavioral case management files reviewed, there were 8 applicable files (i.e., members with a hospitalization). Of these 8, 5 met the discharge planning requirement. **Recommendation** The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO should address this opportunity in the IET PIP, as well as more broadly for the behavioral health population. <u>MCO Response:</u> 1. The plan will educate our staff on the EQRO audit recommendations. 2. UM includes case management in their bi-weekly meeting. UM care advocates are prompted to include case management when involvement is beneficial for the member -- this has been in place since approximately May 2019. 3. Discharge planning from an interdisciplinary perspective is in place -		eight (8) of the 10 case management files reviewed. Seven (7) of the applicable files met this requirement. This requirement was applicable to five (5) of the 10 behavioral health case management files. None (0) of the 5 applicable files met this requirement. **<u>Recommendation</u>** The MCO should improve the discharge planning process and successful member contacts by cross-departmental communication and collaboration, for example, UM and CM, BH advocates and CM. The MCO is also advised to investigate improvements to system notifications to facilitate early identification, documentation and communication of member hospitalizations. The MCO should address this opportunity in the IET/FUA PIP, as well as more broadly for the behavioral health population.	coordination.

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**
			including inpatient case management, utilization management, and case management. The UM team begins the discharge plan at the time of admission. After reviewing the facility's discharge plan, the UM team can make recommendations if they identify gaps/issues/concerns with the member. High needs members are being identified through a specific report and addressed in this interdisciplinary process. UM engages in discharge discussions at the beginning of the member's inpatient stay. 4. Training for the case managers was completed July 8th. The training included: • CHW scope of practice o Individuals with a SUD need a referral to a BHA to address SUD component of gaps in care o Referrals and resources related to SUD or other BH needs are best addressed by BHA • Team opportunities field visits o CHWs, RNs, and BHAs can conduct a collaborative field visit in any member's home (especially members with BH needs or SUD) o Leverage technology when possible (Web-ex for virtual visit if BHA not in area/ Chris, Karen and Shelby will need Web-ex access) • Provider access o Live and Work Well for Virtual BH visits • MAT (medication assistance therapy) providers o Medical providers are able to provide MAT		

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**
			• Peer support education o Currently 1 internal PSS to support all of Louisiana (time is split ½ PSS and ½ PSH) o Possible resources for external peer support specialist teams 5. Quality is working with the Community Healthcare Workers to support through education on how to provide members with information when SUD or BH issues are present. **Final Review Determination**: No change in determination. The plan agreed to the recommendation moving forward, with several actions implemented during the current period, although after the review period.			
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	P/P for care coordination	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**
	home.					
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 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.	P/P for care coordination Includes Care Management File Review	Full			
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	P/P care coordination Court proceedings	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**
	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					
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	**Continuity for Behavioral Health Care**					
6.36.1	The PCP shall provide basic behavioral 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.	P/P for BH care continuity Provider contract Provider manual/handbook	Full			
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	P/P for BH care continuity	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**
	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.					
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,	P/P for BH care continuity	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**
	cost-effectiveness of care.					
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 identification and screening of behavioral health conditions and referral procedures.	P/P for BH care continuity	Full			
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	P/P provider contracting	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**
	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.	Provider contracts				
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 regarding appropriate utilization of emergency room (ER) services, including referral to community behavioral health specialists for behavioral health emergencies, as appropriate;	Member/provider handbook Educational materials	Full			
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			

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**
6.36.9.1.13	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	**Case Management (CM) Policies and Procedures**					
6.40.0	The MCO shall submit Case Management Program policies and procedures to LDH 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:	P/P for CM	Full			
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: Reproductive aged women with a history of prior poor birth outcomes; and 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	P/P for CM Treatment plan template	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**
	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;					
6.40.5	A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment care planning;	P/P for CM	Full			
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	**Case Management Reporting Requirements**					
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	CM/Special health Care needs reports	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**
	provider;					
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 special healthcare needs by the PASRR Level II authority;	CM/Special health Care needs reports	Full			
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	**Chronic Care Management Program (CCMP)**					
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	P/P for CCMP CCMP descriptions	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**
	in the CCMP, to LDH.					
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			
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	P/P for CCMP CCMP descriptions	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**
	Program; and					
6.42.4.11	Include Program Evaluation requirements.	P/P for CCMP CCMP descriptions	Full			
6.44	**CCMP Reporting Requirements**					
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) days prior to due date of those reports.	Communications to LDH	Not Applicable This report is no longer required.			
6.44.2	The CCMP reports shall contain at a minimum:					
6.44.2.1	Total number of members;	CCMC reports	Not Applicable This report is no longer required.			
6.44.2.2	Number of members in each stratification level for each chronic condition; and	CCMC reports	Not Applicable This report is no longer required.			
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 report is no longer required.			
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 the UM Program Description and the Nonquantitative treatment Limits (NQTL) Request for Information document.	

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**
	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 the LA Integrated Health Services Handbook.	
	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 the Coordination of Behavioral Health Care Policy.	
	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 the Do, Louisiana (LA) ABA Chisholm PAL Authorization Management Workflow	
	ABA service shall not be denied solely because a member does not have an Autism Spectrum Disorder (ASD) diagnosis.	Statement of Covered Benefits			This requirement is addressed in the Level of Care Guidelines policy.	

Reporting

Reporting						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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**
4.5	**Written Policies, Procedures, and Job Descriptions**					
18.0	The MCO shall develop and maintain written policies, procedures and job descriptions for each functional area, including for specialized behavioral health services, consistent in format and style. The MCO shall maintain written guidelines for developing, reviewing and approving all policies, procedures and job descriptions. All policies and procedures shall be reviewed at least annually to ensure that the MCO's written policies reflect current practices. Reviewed policies shall be dated and signed by the MCO's appropriate manager, coordinator, director or administrator.	P/P MCO Policy Development and Approval		Full	This requirement is partly addressed in the R_18 UHC_LA_EQRO Medical Policy Development Review Process. However, the document has an effect date on 06/04/2020, which is out of review period. Also, there is no documentation for the job descriptions. **<u>Recommendation</u>** The MCO should include a more detailed job description review, and provide the documents within the review period. **<u>IPRO Final Review Determination:</u>** After additional documentation was provided showing UnitedHealthcare's process for annual review of job descriptions, this element was changed to Full Compliance.	R_02 Narrative for Job Description Revie After subsequent review by IPRO of documentation submitted on 9/1/2020 showing UnitedHealthcare's process for annual review of job descriptions, this element should be changed to Full Compliance.
18.0	**Reporting**					
18.0	As per 42 CFR §438.242(a)(b)(1)-(3), the MCO shall maintain a health information system that collects, analyzes, integrates and reports data that complies with DHH and federal reporting requirements. The system must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and member disenrollment for reasons other than loss of Medicaid	Screen shot of health informatics system System reports		Full	This requirement is addressed in the Management Information Reports for 2018 and 2019 and in the Member Complaints and Grievances Report.	

Reporting						
Contract Reference	**Contract Requirement Language (Federal Regulation: 438.242)**	**Suggested Documentation and reviewer instructions**	**Plan Documentation (MCO please indicate policy number, page number reference to the supporting documentation)**	**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**
	eligibility. The MCO shall collect data on member and provider characteristics and on services furnished to members.					