



# 2025 External Quality Review Compliance Review

*for*

## Healthy Blue

*December 2025*



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## 1. Executive Summary

### Introduction

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the Louisiana Department of Health (LDH) or an external quality review organization (EQRO) may perform the mandatory and optional external quality review (EQR) activities, and the data from these activities must be used for the annual EQR and technical report described in 42 CFR §438.350 and §438.364. One of the four mandatory activities required by the Centers for Medicare & Medicaid Services (CMS) is:

- A review, conducted within the previous three-year period, to determine the managed care organization's (MCO's), prepaid ambulatory health plan's (PAHP's), or prepaid inpatient health plan's (PIHP's) compliance with the standards set forth in Subpart D of this part (42 CFR §438), the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

As LDH's EQRO, Health Services Advisory Group, Inc. (HSAG) is contracted to conduct the compliance review (CR) activity with each of the Healthy Louisiana MCOs, PAHPs, and the PIHP delivering services to members enrolled in the Louisiana Medicaid managed care program. When conducting the CR, HSAG adheres to the methodologies and guidelines established in CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).<sup>1</sup>

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<sup>1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Apr 1, 2025.

## Summary of Compliance Review Results

Table 1-1 presents an overview of the results of the 2025 CR for Healthy Blue (HBL). HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Section 2. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all standards. Refer to appendices B and C for a detailed description of the findings.

**Table 1-1—Summary of Scores for Each Standard**

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
I	Enrollment and Disenrollment Requirements and Limitations	12	9	9	0	3	100%
II	Member Rights and Confidentiality	24	24	23	1	0	96%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	12	1	0	92%
V	Adequate Capacity and Availability of Services	15	14	8	6	1	57%
VI	Coordination and Continuity of Care	12	12	10	2	0	83%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	18	1	0	95%
IX	Subcontractual Relationships and Delegation	6	6	3	3	0	50%
X	Practice Guidelines	6	6	6	0	0	100%
XI	Health Information Systems	9	9	9	0	0	100%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	32	5	1	86%
XIV	Program Integrity	18	18	18	0	0	100%
<b>Total Compliance Score</b>		<b>227</b>	<b>217</b>	<b>192</b>	<b>25</b>	<b>10</b>	<b>88%</b>

*M=Met, NM=Not Met, NA=Not Applicable*

**Total Elements:** The total number of elements in each standard.

**Total Applicable Elements:** The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

**Total Compliance Score:** The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

## 2. Methodology

### Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs’ compliance with standards set forth in 42 CFR Part 438. To complete this requirement, HSAG, through its EQRO contract with LDH, performed CRs of the six MCOs, two PAHPs, and one PIHP contracted with LDH to deliver services to Louisiana Medicaid managed care members.

During the 2025 CR process, LDH requested that HSAG review the performance of the managed care entities (MCEs) for compliance with all regulations at 42 CFR Part 438 and applicable state-specific requirements. Table 2-1 outlines the division of standards reviewed in calendar year (CY) 2021, CY 2022, CY 2023, and CY 2024.

**Table 2-1—CR Standards**

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard I— Enrollment and Disenrollment Requirements and Limitations	§438.56				✓	✓	✓	-	✓	✓	✓
Standard II— Member Rights and Confidentiality	§438.100 §438.224	✓	✓	✓				-	✓	✓	✓
Standard III— Member Information	§438.10	✓	✓	✓				-	✓	✓	✓
Standard IV— Emergency and Poststabilization Services	§438.114	✓	NA				✓	-	✓	✓	✓
Standard V— Adequate Capacity and Availability of Services	§438.206 §438.207	✓	✓	✓				-	✓	✓	✓
Standard VI— Coordination and Continuity of Care	§438.208	✓	✓	✓				-	✓	✓	✓

Standard	CFR	CY 2021			CY 2022			CY 2023*	CY 2024		
		MCO	PAHP	PIHP	MCO	PAHP	PIHP	MCEs	MCO	PAHP	PIHP
Standard VII—Coverage and Authorization of Services	§438.210	✓	✓	✓				-	✓	✓	✓
Standard VIII—Provider Selection	§438.214	✓	✓	✓				-	✓	✓	✓
Standard IX—Subcontractual Relationships and Delegation	§438.230	✓		✓		✓		-	✓	✓	✓
Standard X—Practice Guidelines	§438.236	✓	✓	✓				-	✓	✓	✓
Standard XI—Health Information Systems	§438.242	✓	✓	✓				-	✓	✓	✓
Standard XII—Quality Assessment and Performance Improvement	§438.330	✓	✓	✓				-	✓	✓	✓
Standard XIII—Grievance and Appeal Systems	§438.228	✓	✓	✓				-	✓	✓	✓
Standard XIV—Program Integrity	§438.608	✓	✓	✓				-	✓	✓	✓

<sup>1</sup> The CR standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard XIII—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

\* No CR was conducted for CY 2023 for the Louisiana MCEs.

This report presents the results of the 2025 CR, review period CY 2024 (January 1, 2024–December 31, 2024). LDH and the individual MCEs use the information and findings from the CRs to:

- Evaluate the quality, timeliness, and accessibility of healthcare services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

## Technical Methods of Data Collection and Analysis

Prior to beginning the CR, HSAG developed data collection tools, referred to as “CR tools,” to document the review. The content in the tools was selected based on applicable federal and state-specific regulations as they related to the scope of the review. The review processes used by HSAG to evaluate the MCEs’ compliance were consistent with CMS EQR Protocol 3.

For each of the MCEs, HSAG’s desk review consisted of the following activities.

### Pre-Virtual Review Activities

- Collaborated with LDH to develop the scope of work, CR methodology, and CR tools.
- Prepared and forwarded to each of the MCEs a detailed timeline, description of the CR process, document request packet, and a post-interview follow-up document.
- Scheduled the virtual review with the MCE.
- Hosted a pre-virtual review preparation session with all MCEs.
- Generated a sample of cases for file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG’s preliminary desk review.
- Developed an agenda for the virtual review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG’s review.

### Virtual Review Activities

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG’s review activities.
- Interviewed MCE key program staff members.
- Conducted an information systems (IS) review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.
- Discussed the post-interview follow-up document that lists the additional documentation requested by HSAG.

### Post-Virtual Review Activities

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score (*Met* or *Not Met*) within the CR tool, as described in the Data Aggregation and Analysis section below.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its CAPs for each element that received a *Not Met* score.

## Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3.

*Met* indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, file reviews, and IS reviews confirmed implementation of the requirement.

*Not Met* indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present, and staff members have little, or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across all areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCE's records for appeals, case management, delegation, grievances, organizational credentialing, practitioner credentialing, and service authorization denials to verify that the MCE had put into practice what the MCE had documented in its policies. HSAG selected 10 records with an oversample of two records for appeals, grievances, and service

authorization denials from the full universe of records provided by the MCE. HSAG selected 10 records for case management with an oversample of five records for the PAHPs and PIHP. HSAG selected five records with an oversample of one record for organizational credentialing and practitioner credentialing from the full universe of records provided by the MCE. HSAG selected three records with an oversample of one record for delegation from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the CR tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services the MCE provided to members, HSAG aggregated and analyzed the data resulting from its desk and virtual review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Determined opportunities for improvement, recommendations, and corrective actions required based on the review findings.

## Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Files for file review.
- Member and provider materials.

HSAG obtained additional information for the CR through interactions, discussions, and interviews with the MCE’s key staff members. Table 2-2 lists the major data sources HSAG used to determine the MCE’s performance in complying with requirements and the time period to which the data applied.

**Table 2-2—Description of MCE Data Sources and Applicable Time Period**

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during and after the site review	January 1, 2024–December 31, 2024
Information obtained through interviews	August 2025-September 2025
Information obtained from a review of a sample of files	January 1, 2024–December 31, 2024

### 3. Corrective Action Plan Process








HBL is required to submit to the HSAG SAFE site a CAP for all elements scored as *Not Met*. Appendix C contains the CAP template that HSAG prepared for HBL to use in preparing its plans of action to remediate any deficiencies identified during the 2025 CR. The CAP template lists each element for which HSAG assigned a score of *Not Met*, as well as the associated findings and required actions documented to bring HBL into full compliance with the deficient requirements. HBL must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). HBL's CAP template and evidence of implementation must be submitted to the HSAG SAFE site **no later than 60 calendar days from receipt of the final report**.

The following criteria will be used by HSAG and LDH to evaluate the sufficiency of the CAP:


- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific plans of action/interventions that HBL will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions brought HBL into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Any CAPs that do not meet the preceding criteria will require resubmission by the MCO until approved by HSAG and LDH. LDH maintains ultimate authority for approving or disapproving any corrective action strategies proposed by HBL in its submitted CAP.

## Appendix A. Conclusions and Recommendations

Strengths	
	The MCE’s policies and procedures ensured that the MCE did not request disenrollment of a member because of an adverse change in the member’s health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. Furthermore, the MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations.
	The MCE received 100 percent compliance with Standard IV—Emergency and Poststabilization Services, demonstrating that the MCE had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services.
	The MCE consistently met timeliness requirements for prior authorization decisions. Additionally, the MCE received 100 percent compliance with Standard VII—Coverage and Authorization of Services, demonstrating that the MCE had a thorough and comprehensive approach for review, authorization, and denial of services.
	The MCE effectively adopted practice guidelines in consensus with network providers and had a system in place for dissemination to providers and members. In addition, the MCE received 100 percent compliance with Standard X—Practice Guidelines.
	The MCE received 100 percent compliance with Standard XI—Health Information Systems, demonstrating that the MCE had a robust health information system for processing and managing member data, provider data, and claims processing, while ensuring data security and facilitating data reporting.
	The MCE received 100 percent compliance with Standard XII—Quality Assessment and Performance Improvement and demonstrated detailed documentation, indicated methods to monitor quality of care, analyzed over- and underutilization, and ensured improved outcomes for members with special health care needs.
	The MCE received 100 percent compliance with Standard XIV—Program Integrity, demonstrating that the MCE had appropriate processes to monitor, identify, plan, and mitigate fraud, waste, and abuse. Furthermore, the MCE developed a compliance committee to ensure information sharing at the staff, management, and leadership levels.

### Summary Assessment of Opportunities for Improvement, Required Actions, and Recommendations

	The MCE should review the CR tool and its detailed findings and recommendations. Specific required actions and recommendations are made that, if implemented, should demonstrate compliance with requirements and positively impact member outcomes.
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## Appendix B. 2025 Compliance Review Tool

This appendix includes the completed review tool that HSAG used to evaluate HBL’s performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring HBL’s performance into full compliance.



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Disenrollment Requested by the MCE</b>		
<p>1. The MCE may request disenrollment of a member in the following circumstances:</p> <ol style="list-style-type: none"> <li>a. <i>When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department</i></li> <li>b. <i>Upon termination or expiration of the Contract</i></li> <li>c. <i>Death of the member</i></li> <li>d. <i>Confinement of the member in a facility or institution when confinement is not a covered service under the Contract</i></li> </ol> <p><b>PAHP:</b> <i>The Contractor may request involuntary disenrollment of an enrollee if the enrollee’s utilization of services constitutes fraud, waste, and/or abuse such as misusing or loaning the enrollee’s ID card to another person to obtain services. In such case the Contractor shall report the event to LDH and the Medicaid Fraud Control Unit (MFCU).</i></p> <p><b>PIHP:</b></p> <ol style="list-style-type: none"> <li>a. <i>The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.</i></li> </ol> <p style="text-align: right;">42 CFR §438.56(b)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.12.3.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• State-specific workflow for MCE-initiated disenrollment requests</li> <li>• Member materials, such as the member handbook</li> <li>• One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request (if the MCE has not requested disenrollment of a member please state so under the <i>MCE Description of Process</i>)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01-07 Enrollment and Disenrollment Policy- LA, page 1 policy and product header, section 2 (Definitions), page 1 section 2 (Procedure)</li> <li>• 01-07 Enrollment and Disenrollment Policy LA page 6 section <i>Involuntary Disenrollment Requested by Healthy Blue</i>. the ID card, in which event the matter must be reported to the LDH and MFCU.</li> <li>• Healthy Blue Member Handbook 12 23.pdf, pages 85-86, “Reasons why you can be disenrolled from Healthy Blue”</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Healthy Blue can confirm that there have been no MCE initiated disenrollments in 2024.</li> <li>HBL Disenrollment Approval Process (Screenshot)</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue requests involuntary disenrollment for members engaged in fraud, waste, or abuse, including misuse of ID cards for unauthorized service access. These cases are reported to LDH and MFCU. Requests for disenrollment are submitted via the Enrollment Broker per LDH's format.</p> <p>Healthy Blue maintains documentation of involuntary disenrollment, ensuring no requests are made based on adverse health changes, diagnosis, service utilization, or member rights actions. Disenrollment cannot be requested for members' uncooperative behavior due to special needs unless it impairs Healthy Blue's service delivery.</p> <p>All disenrollment requests are reviewed by LDH or its Enrollment Broker, with decisions being final. Healthy Blue continues service provision until disenrollment is finalized. Disenrollment is effective by the first day of the second month post-request, and any disenrollment approval includes reasons, effects, and member appeal rights.</p> <p>Disenrollment requests stemming from fraud or behavioral issues require additional documentation, and Healthy Blue must promptly inform LDH of member status changes affecting eligibility. Reconciliation of enrollment/disenrollment data is conducted monthly.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
2. The MCE does not request disenrollment because of: MCO & PAHP: <ol style="list-style-type: none"> <li>a. An adverse change in the member's health status; or</li> <li>b. Because of the member's health diagnosis</li> <li>c. The member's utilization of medical services</li> </ol>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Report of MCE-initiated requests for disenrollment of members during the past 12 months, including the reason for requesting the disenrollment (if the MCE has not requested</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>d. The member’s diminished mental capacity</p> <p>e. The member’s pre-existing medical condition</p> <p>f. The member’s refusal of medical care or diagnostic testing</p> <p>g. The member’s attempt to exercise his/her rights under the Contractor’s Grievance system</p> <p>h. The member’s attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned</p> <p>i. Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCE seriously impairs the MCE’s ability to furnish services to either this particular member or other members).</p> <p>PIHP:</p> <p>a. The member's adverse change in health status</p> <p>b. The member’s utilization of medical services</p> <p>c. The member’s diminished mental capacity</p> <p>d. The member’s uncooperative or disruptive behavior resulting from his or her special needs</p> <p style="text-align: right;">42 CFR §438.56(b)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5</p>	<p>disenrollment of a member please state so under the <i>MCE Description of Process</i>)</p> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Pp. 6 – 8, sections “Involuntary Disenrollment Requested by Healthy Blue” and “Voluntary Disenrollment Requested by the Member”</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Healthy Blue can confirm that there have been no MCE initiated disenrollments in 2024.</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue processes both voluntary and involuntary disenrollment requests compliant with state and federal regulations. Voluntary disenrollment can occur for reasons like poor quality of care or unsuitable contracted services, while involuntary</p>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>disenrollment may result from fraudulent activity. However, disenrollment is prohibited based on health changes, diagnosis, or service utilization.</p> <p>Requests require approval by LDH, with decisions made by the Enrollment Broker. Healthy Blue maintains care responsibility until disenrollment is finalized.</p> <p>Key Elements of this process are:</p> <ul style="list-style-type: none"> <li><b>Contact:</b> For support, members contact the Enrollment Broker.</li> <li><b>Voluntary Disenrollment:</b> Request anytime for valid reasons; unrestricted within specific timeframes.</li> <li><b>Involuntary Disenrollment:</b> Possible if fraud is evident; requires LDH approval.</li> <li><b>Prohibited Criteria:</b> Health changes, uncooperative behavior due to special needs, etc., cannot prompt disenrollment.</li> <li><b>Decision Process:</b> LDH reviews requests, and decisions are final.</li> </ul> <p>Healthy Blue ensures compliance, non-discrimination, and the provision of necessary medical services throughout the disenrollment process.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract.</p> <p>MCO &amp; PAHP:</p> <p>a. In accordance with 42 CFR §438.56(b)(3), LDH shall ensure that the MCO/PAHP is not requesting disenrollment for other reasons by reviewing and rendering decisions on all Disenrollment Request Forms submitted to the enrollment broker.</p> <p>PIHP:</p> <p>a. The PIHP shall not request disenrollment for reasons other than those stated in the Contract. The PIHP may not disenroll Coordinated System of Care (CSoC)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Staff training materials</li> <li>One case example of an MCE-initiated request for disenrollment of a member, including supporting documentation of the reason for the request and the outcome of the disenrollment request</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, pages 5-6</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>members for any reason other than discharge from CSoC. Eligible members may choose to no longer participate in CSoC, in which case specialized behavioral health services will be transitioned to the Integrated Medicaid Managed Care Program Contractor effective the first day of the month following discharge.</p> <p style="text-align: right;">42 CFR §438.56(b)(3) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6</p>		
<p><b>MCE Description of Process:</b> Healthy Blue's disenrollment process complies with state requirements as detailed in the "Enrollment and Disenrollment - LA.docx" document. The Managed Care Entity (MCE) reviews all member disenrollment requests. It can approve these requests directly if they meet state criteria, ensuring prompt processing.</p> <p>If a request does not meet the criteria, the MCE refers it to the State for further review. This dual-pathway ensures that all requests are handled appropriately and maintain compliance with 42 CFR §438.56, guaranteeing timely and fair processing for members</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Disenrollment Requested by the Member		
<p>4. The member may request disenrollment from the MCE as follows:</p> <p style="margin-left: 20px;">a. Without cause, at the following times:</p> <p style="margin-left: 40px;">MCO:</p> <p style="margin-left: 60px;">i. During the disenrollment period offered to Enrollees at the start of the contract.</p> <p style="margin-left: 60px;">ii. During the 90 days following the date of the member's initial enrollment into the MCE, or</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, page 84, "How to disenroll from Healthy Blue"</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.</p> <p>iii. At least once every 12 months thereafter (during the enrollment period).</p> <p>iv. At least once every 12 months thereafter.</p> <p>v. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.</p> <p>vi. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.</p> <p>vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p><b>PAHP:</b></p> <p>i. During the 90 days following the date of the member’s initial enrollment into the MCE, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.</p> <p>ii. At least once every 12 months thereafter.</p> <p>iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary loss of Medicaid</p>	<ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf. pages 85- 86 "Reasons why you can be disenrolled from Healthy Blue”</li> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, Pp. 5 through 9 section Voluntary Disenrollment Requested by the Member</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>eligibility has caused the member to miss the annual disenrollment opportunity.</p> <p>iv. When the State imposes the intermediate sanction specified in §438.702(a)(4)—suspension of all new enrollment, including default enrollment, after the date the Secretary or the State notifies the MCE of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.</p> <p>v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</p> <p style="text-align: right;">42 CFR §438.56(c) 42 CFR §438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA</p>		
<p><b>MCE Description of Process:</b> Healthy Blue adheres to disenrollment protocols to meet compliance requirements outlined in the "Enrollment and Disenrollment - LA document. Members can request disenrollment for specific causes or without cause during the first 90 days of enrollment, annually, or under certain conditions such as contract termination or state-imposed sanctions (42 CFR §438.56).</p> <p><b>Disenrollment for Cause:</b> Members can disenroll due to service access issues, poor quality of care, moral or religious objections, or other LDH-validated reasons.</p> <p><b>Process Compliance:</b> Requests for disenrollment must be submitted to the Enrollment Broker and are subject to LDH review. The effective disenrollment date is no later than the start of the second month following the request. All decisions are final, ensuring process integrity and regulatory compliance.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Procedures for Disenrollment</b>		
<p>5. The following are causes for disenrollment:</p> <p>MCO:</p> <ul style="list-style-type: none"> <li>a. The member moves out of the MCE’s service area;</li> <li>b. The MCE does not (due to moral or religious objections) cover the service the member seeks;</li> <li>c. The member needs related services to be performed at the same time; not all related services are available from the MCE’s plan, and the member’s primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk;</li> <li>d. Poor quality of care;</li> <li>e. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</li> <li>f. The Contract between the MCE and LDH is terminated;</li> <li>g. The member’s active specialized behavioral health provider ceases to contract with the MCE for reasons other than noncompliance with the Network Provider Agreement of this Contract; or</li> <li>h. Any other reason deemed to be valid by LDH and/or its agent.</li> </ul> <p>PAHP:</p> <ul style="list-style-type: none"> <li>a. The MCE does not (due to moral or religious objections) cover the service the member seeks;</li> </ul>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01-07 Enrollment and Disenrollment – LA Policies and Procedures, page 5 under the section titled "Voluntary Disenrollment Requested by the Member</li> <li>• Healthy Blue Member Handbook 12 23.pdf, pages 83 - 85</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>b. The member needs related services to be performed at the same time, not all related services are available from the MCE’s plan, and the member’s primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk;</p> <p>c. Poor quality of care;</p> <p>d. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</p> <p>e. The Contract between the MCE and LDH is terminated;</p> <p>f. Any other reason deemed to be valid by LDH and/or its agent.</p> <p style="text-align: right;">42 CFR §438.56(d)(2) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA</p>		
<p><b>MCE Description of Process:</b> Healthy Blue complies with member disenrollment requirements through clear procedures outlined in the "Healthy Blue Member Handbook" and the "Enrollment and Disenrollment policies and procedures. Members can request disenrollment for specific causes, such as moving out of the service area, moral objections, poor quality of care, and lack of service access. Requests can also be made without cause within 90 days of initial enrollment, annually, or during other specified periods.</p> <p>Disenrollment requests are submitted through the Enrollment Broker and require LDH approval, ensuring compliance with 42 CFR §438.56. Healthy Blue provides comprehensive support and communication throughout the process, maintaining service coverage until disenrollment is finalized. This structured approach ensures regulatory adherence and member empowerment.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>6. The member must request disenrollment by submitting an oral or written request (as required by the State):</p> <p style="margin-left: 20px;">a. To the State or its agent; or</p> <p style="margin-left: 20px;">b. To the MCE, if the State permits MCEs to process disenrollment requests.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(1) 42 CFR §457.1212</p> <p>MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Workflow delineating State and MCE responsibilities</li> <li>Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 83- 85</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Disenrollment and Enrollment - Medicaid desktop procedure</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue's disenrollment processes are structured to comply with state requirements, ensuring members can request disenrollment through oral or written requests, in alignment with both the "Healthy Blue Member Handbook" and "Enrollment and Disenrollment Policies and Procedures. Members can initiate disenrollment by contacting the Healthy Louisiana Enrollment Center or Member Services, either orally or in writing. Requests are then processed by the Enrollment Broker, who ensures state approval and appropriate documentation. The Enrollment Broker manages all disenrollment functions, ensuring accuracy and timely processing.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>7. When the MCE’s contract with the State permits the MCE to process disenrollment requests, the MCE may either approve a request for disenrollment by or on behalf of a member or the MCE must refer the request to the State.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(i) 42 CFR §457.1212</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter, review conducted by the MCE, decision made by the MCE, reporting to the State)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, page 5 section “Voluntary Disenrollment Requested by the Member”</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue's disenrollment process complies with state requirements as detailed in the "Enrollment and Disenrollment - LA.docx" document. The Managed Care Entity (MCE) reviews all member disenrollment requests. It can approve these requests directly if they meet state criteria, ensuring prompt processing.</p> <p>If a request does not meet the criteria, the MCE refers it to the State for further review. This dual pathway ensures that all requests are handled appropriately and maintain compliance with 42 CFR §438.56, guaranteeing timely and fair processing for members</p>		
<p><b>HSAG Findings:</b> The State retains authority over all disenrollment decisions, so the MCE is not able to process a disenrollment request; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Use of the MCE’s Grievance Process</b>		
<p>8. (If the State contract requires) The member must seek redress through the MCE’s grievance process before making a determination on the member’s request:</p> <p style="margin-left: 20px;">a. The grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1)—regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee requests disenrollment or the MCE entity refers the request to the State.</p> <p style="margin-left: 20px;">b. If, as a result of the grievance process, the MCE approves the disenrollment, the State agency is not required to make a determination to approve or disapprove the disenrollment request.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212</p> <p>MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Three case examples of a member request for disenrollment grievance record, including the resolution letter</li> <li>Referrals to the State for member termination from MCE</li> <li>Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, page 8 section disenrollment effective date</li> <li>Healthy Blue Member Handbook 12 23.pdf, page 85 section “How to disenroll”</li> <li>LA Disenrollment Report from Cube, July2024 – June 2025 showing disenrollment reasons</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue members can request disenrollment by submitting an oral or written request to the Enrollment Broker, in line with state requirements. Requests approved by the Enrollment Broker are processed efficiently, maintaining compliance with 42 CFR §438.56 timelines for disenrollment to be effective no later than the first day of the second month following the request. This structured process affirms adherence to regulatory standards, ensuring proper handling of member disenrollment.</p>		
<p><b>HSAG Findings:</b> The State contract does not require a grievance process as described in these requirements; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>9. If the MCE or State agency or its designee fails to make a disenrollment determination so that the member can be disenrolled within the timeframes specified in 42 CFR §438.56(e)(1), the disenrollment is considered approved.</p> <p style="text-align: right;">42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212</p> <p>MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01-07 Enrollment and Disenrollment – LA Policies and Procedures, page 8 section Disenrollment Effective Date</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue's disenrollment policy mandates that disenrollment requests be submitted to the Enrollment Broker, who ensures timely processing and state approval, adhering to 42 CFR §438.56 requirements. If the MCE, State, or its designee fails to make a timely determination, the disenrollment is considered approved by default, ensuring compliance with federal timelines. These procedures uphold member rights and maintain regulatory conformance, ensuring that disenrollment requests are handled efficiently and in accordance with established guidelines.</p>		
<p><b>HSAG Findings:</b> The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Enrollment		
<p>10. The MCE agrees to accept individuals enrolled into its MCE in the order in which they apply without restriction (unless authorized by the Department). The MCE may not prescreen select potential members on the basis of pre-existing health problems.</p> <p>MCO and PAHP:</p> <p>a. <i>The Contractor shall accept new Enrollment of Beneficiaries in the order in which they are submitted by the Enrollment Broker without restriction as specified by LDH, up to the limits set under the</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>•</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01-07 Enrollment and Disenrollment – LA Policies and Procedures, page 1</li> <li>• Healthy Blue Member Handbook 12 23.pdf, page 10</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Membership Load – Facets policy</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p><i>Contract with LDH [42 CFR §438.3(d)(1)]. Enrollment is voluntary, except in the case of Mandatory MCO Populations that meet the conditions set forth in 42 CFR §438.50(a).</i></p> <p><b>PIHP:</b></p> <p>a. <i>The Contractor shall accept referrals of individuals for CSoC consideration in the order in which they are referred, without restriction. The Contractor shall complete the brief CANS in order to determine if the child/youth is presumptively clinically eligible for CSoC. If the child/youth meets presumptive clinical eligibility, the Contractor will build a thirty (30) day authorization and make referral within twenty-four (24) hours to the WAA. The Contractor shall make a referral to the FSO within twenty-four (24) hours of notification of member’s choice. The WAA shall ensure that the independent assessment is conducted to determine clinical eligibility.</i></p> <p style="text-align: right;">42 CFR §438.3(d)(1)</p> <p>MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2</p>		
<b>MCE Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>11. The MCE does not discriminate against individuals enrolled or use any policy or practice that has the effect of discriminating against individuals, based on health status or need for healthcare services, race, color, national origin, sex, or disability.</p> <p style="text-align: right;">42 CFR §438.3(d)(3-4)</p> <p>MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Enrollment policies and procedures</li> <li>Member handbook</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, pages 2, 6-7</li> <li>Healthy Blue Member Handbook 12 23.pdf, pages 10-11 “Information about your new health plan”</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Membership Load – Facets policy</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> In Healthy Blue’s process for disenrollment requests, members can request disenrollment for valid reasons such as service access or quality issues. Requests must be submitted to the Enrollment Broker, who ensures state review and approval. Healthy Blue adheres to non-discriminatory enrollment and disenrollment practices, ensuring equitable access for all eligible members. Disenrollment timelines are followed, with auto-approval if determinations aren't made timely, ensuring adherence to federal requirements. These procedures collectively uphold regulatory standards, safeguarding member rights, and maintaining service integrity.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>12. If the Department approves the MCE’s disenrollment request, the MCE gives the member 30 days written notice of the proposed disenrollment and notifies the member of his or her right to submit a request for a State Fair Hearing.</p> <p>MCO:</p> <p>a. The notice shall include:</p> <p style="padding-left: 20px;">i. The reason for the disenrollment;</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Enrollment policies and procedures</li> <li>Member notification letter template</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>01-07 Enrollment and Disenrollment – LA Policies and Procedures, 6-11</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>ii. The effective date of the disenrollment;</li> <li>iii. An instruction that the Enrollee choose a new MCO; and</li> <li>iv. A statement that if the Enrollee disagrees with the Disenrollment decision, the Enrollee has a right to submit a request for a State Fair Hearing.</li> </ul> <p>PAHP:</p> <ul style="list-style-type: none"> <li>a. The notice shall include:               <ul style="list-style-type: none"> <li>i. The reason for the disenrollment;</li> <li>ii. The effective date;</li> <li>iii. An instruction that the enrollee choose a new DBPM; and</li> <li>iv. A statement that if the enrollee disagrees with the decision to disenroll, the enrollee has a right to submit a request for a State Fair Hearing.</li> </ul> </li> </ul> <p style="text-align: right;">42 CFR §438.56(d)(5)</p> <p>MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA</p>	<ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, page 89</li> <li>• HBL Nondiscrimination policy</li> <li>• Member notification letter template – LA</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• During the review period of 2024, Healthy Blue maintained its commitment to serving all members effectively. It is not common practice for Healthy Blue to request disenrollment of members from the LDH. Therefore, there were no requests for disenrollment of any member made during this period.</li> </ul>	
<p><b>MCE Description of Process:</b> If the Department approves the MCE's disenrollment request, Healthy Blue provides members with a 30-day written notice of the proposed disenrollment, this notice includes:</p> <ul style="list-style-type: none"> <li>• The reason for the disenrollment.</li> <li>• The effective date of the disenrollment.</li> <li>• Instructions for the enrollee to choose a new Managed Care Organization (MCO).</li> <li>• A statement informing the enrollee of their right to request a State Fair Hearing if they disagree with the disenrollment decision.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Recommendations:</b> HSAG recommends that the MCE develop a letter template in the event that it would require an MCE-initiated disenrollment.		
<b>Required Actions:</b> No action required.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
<b>Total</b>	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	3				
<b>Total Applicable</b>		=	9	<b>Total Score</b>		=	9
<b>Total Score ÷ Total Applicable</b>						=	<b>100%</b>



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Standard II—Member Rights and Confidentiality**

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<b>General Rule</b>		
<p>1. The MCE has written policies regarding member rights.</p> <p style="text-align: right;">42 CFR §438.100(a)(1) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Member rights policy</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1 Provider and Member Bill of Rights LA</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Member Rights and Responsibilities – LA.pdf</li> <li>P-02.1 Notice Policy and Procedure.pdf</li> <li>P-03.1 Authorizations and Consent Policy.pdf</li> <li>P-06.1 Access to Protected Health Information (PHI), Amendment, and Accounting of Disclosures Policy and Procedure.pdf</li> <li>P-09.2 Monitoring and Enforcement Policy and Procedure.pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The Provider and Member Bill of Rights ensures that network providers, contracted to deliver services, can advise and advocate for members within their practice scope, thereby supporting members' rights to informed health decisions. It mandates that members receive essential information about their health status, treatment options, and the ability to participate in healthcare decisions, including refusal rights. Furthermore, it protects members from discrimination and ensures transparency in service authorization decisions, aligning with federal regulations. This comprehensive framework provides mechanisms for grievances, appeals, and access to policy information, thus demonstrating the health plan’s commitment to safeguarding member rights as stipulated by LDH requirements</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>2. The MCE complies with any applicable Federal and State laws that pertain to member rights and ensures that it’s employees and contracted providers observe and protect those rights.</p> <p style="text-align: right;">42 CFR §438.100(a)(2) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures</li> <li>Provider materials, such as the provider manual, provider contract, and provider training materials</li> <li>Employee training materials</li> <li>Auditing/oversight mechanisms</li> <li>Grievance log over the time period of review with member rights grievances</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures</li> <li>Healthy Blue Provider Manual_2023.pdf (Pg. 69-70)</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24Pg.6 / All</li> <li>Grievance Log – Element 5 Screenshot</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Policies and Procedures</p> <p>The Managed Care Entity (MCE) has a well-structured process in place for ensuring compliance with applicable Federal and State laws related to member rights, effectively engaging contracted providers in the protection and observance of these rights. As demonstrated in the "Standard VI_Healthy Blue Provider Manual_2023.pdf," the document comprehensively outlines the protocols and procedures necessary for maintaining compliance. It includes sections like "Provider Bill of Rights" and "Healthy Blue Member Rights and Responsibilities," which set clear expectations for providers to align their practices with legal standards, ensuring non-discrimination and informed consent. Additionally, the manual emphasizes the importance of the grievance process, encouraging members to voice concerns about their care, thus supporting the enforcement of member rights. This provider manual serves as a crucial resource for education and guidance, setting standards that both uphold</p>		



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Requirement	Supporting Documentation	Score
<p>member protections and fulfill legal obligations, thereby illustrating Healthy Blue's commitment to meeting the mandated compliance requirement.</p> <p><b><u>2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24:</u></b></p> <p>All associates must complete our new hire and annual “Do the Right Thing” learning program. Screenshot of the Grievance log provided</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Specific Rights		
<p>3. The MCE complies with the requirements listed in the Member Rights Checklist.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.100(b-d) 42 CFR §457.1220</p> <p>MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures</li> <li>Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec2</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Resubmitted Member Checklist documentation (see checklist for corresponding documentation)</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue has provided the Do the Right thing full script which also includes information regarding member rights.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. During the interview session, HBL staff members were unable to fully describe how HBL ensures members’ right to be furnished healthcare services in accordance with 42 CFR</p>		



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<p>§438.206 through §438.210 and were given the opportunity to resubmit the checklist. The resubmitted checklist did not include sufficient documentation to demonstrate how HBL ensured compliance with member rights by its employees and providers.</p>		
<p><b>Required Actions:</b> The MCE must improve its documentation for how the MCE ensures member rights are protected, pertaining to 42 CFR §438.206 through §438.210. In addition to the member rights listed in HBL’s member handbook, HBL needs to be able to demonstrate (via policies, procedures, trainings, or provider contracts) how it ensures members’ rights. Please see the Member Rights Checklist for the specific areas of noncompliance.</p>		
<p>4. For medical records and any other health and enrollment information that identifies a particular member, the MCE uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent that these requirements are applicable.</p> <p>a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO.</p> <p>b. The MCO designates a contact person or office who is responsible for receiving privacy-related complaints and who is able to provide further information about matters covered by the notice required by 45 CFR §164.520.</p> <p>c. The MCO trains all members of its workforce on the policies and procedures with respect to protected health information (PHI) as necessary and appropriate for the members of the workforce to carry out their functions within the MCO as outlined in 45 CFR §164.530.</p> <p>d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures (should address all components of 45 CFR part 164 subpart E)</li> <li>Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records</li> <li>Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information</li> <li>Employee-facing materials</li> <li>Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>4, 5, 7 Minimum Necessary Requirements Policy Pg. 1</li> <li>4 a-c Privacy Program Management Policy Pg. 2, 5, 6</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right; margin-right: 20px;">45 CFR Parts 160 and 164, Subparts A and E</p> <p>MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12</p>	<ul style="list-style-type: none"> <li>4 Use and Disclosure of PHI and Personal Information (PI) within ElevancePg 1-2</li> <li>4d Safeguards Policy Pg 1-2</li> <li>4 Sensitive Information (including Substance Use Disorder) Policy and Procedure (Entire Document (ED) Pg. All</li> <li>4 Corporate Privacy Table of Contents ED Pg. All</li> <li>4 Readiness Disclosure Statement ED Pg. All</li> </ul> <p><b><u>Employee facing materials:</u></b></p> <ul style="list-style-type: none"> <li>4 Elevance Health Code February 2025 final EN Pg. All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Provider Materials:</u></b></p> <ul style="list-style-type: none"> <li>Healthy Blue Provider Manual_2023.pdf (Pg. 13, 14, 69, 78</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue Associates have a responsibility to keep various types of information confidential in accordance with applicable federal and state and international laws, including Protected Health Information (PHI), Personal Information (PI), and Protected Financial Information (PFI). Healthy Blue’s privacy policies and procedure set forth the requirements and guidance Healthy Blue Associates must follow when collecting, using, or disclosing information and sets forth a number of rights Individuals have, pursuant to applicable federal, state, and international laws. Healthy Blue Associates should apply the policy requirements, as applicable, for PHI, PI, and PFI.</p> <p>The Privacy Department develops and approves corporate-wide privacy policies and procedures. These policies and procedures are intended to provide guidance to Healthy Blue as an enterprise, including its business that operates as a Health Plan, a Business Associate, and as a Group Health Plan.</p>		



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p><b><u>4 5 7 Minimum Necessary Requirements Policy</u></b>            Healthy Blue Associates may only collect, use and disclose the minimum amount of Protected Health Information (PHI) necessary to perform job functions.</p> <p><b><u>4 a b c Privacy Program Management Policy</u></b>            Healthy Blue’s privacy policies set forth the guidelines Healthy Blue Associates must follow when collecting, using, or disclosing Individual information and sets forth the rights Individuals have, pursuant to applicable federal, state, and international laws.</p> <p><b><u>4 Use and Disclosure of Protected Health Information (PHI) and Personal Information (PI) within Elevance</u></b>            Healthy Blue Associates may use and share with other Healthy Blue Associates the minimum amount of Personally Identifiable Information (PII) necessary to perform Healthy Blue’s Treatment, Payment and Health Care Operations (TPO).</p> <p><b><u>4 5 Safeguards Policy</u></b>            Healthy Blue Associates are required to safeguard both paper and electronic forms of PHI, confidential and proprietary information.</p> <p><b><u>4 Sensitive Information (including Substance Use Disorder) Policy and Procedure</u></b>            Healthy Blue’s outlined standard for adhering to state law for addressing confidentiality of information.</p> <p><b><u>4 Corporate Privacy Table of Contents:</u></b>            Corporate Privacy table of contents outlines policies, procedures, and guidelines on protecting confidentiality of members health and financial information, and individual privacy rights. Associates and wholly owned affiliates and subsidiaries adhere to these documents.</p> <p><b><u>4 Readiness Disclosure Statement:</u></b>            Readiness disclosure statement.</p> <p><b><u>4 Elevance Health Code February 2025 final EN:</u></b>            All associates must adhere to our Code of Conduct.</p> <p><b><u>2-3, 24 ANTH 04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b>            All associates must complete our new hire and annual “Do the Right Thing” learning program.</p>		



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Requirement	Supporting Documentation	Score
<p>Healthy Blue adheres to the privacy requirements of 45 CFR parts 160 and 164, subparts A and E, to protect individually identifiable health information. We comply with HIPAA by implementing strict policies for using and disclosing health data, obtaining member authorizations, and ensuring only authorized personnel have access. Additionally, we apply necessary safeguards to maintain confidentiality and prevent unauthorized access, ensuring compliance with legal standards.</p> <p>The Healthy Blue Provider Manual outlines the responsibilities and protocols for providers in the network, emphasizing compliance with privacy laws like HIPAA. Providers are required to have mechanisms to prevent unauthorized disclosure of member health information. Providers must implement proper administrative, technical, and physical safeguards to secure protected health information (PHI).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Use and Disclosure of PHI		
<p>5. The MCE and its business associates may not use or disclose protected health information (PHI) except as permitted or required by 45 CFR §164.502 or by 45 CFR §160 subpart C. The MCE is permitted to use or disclose PHI as follows:</p> <ol style="list-style-type: none"> <li>a. To the individual.</li> <li>b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506.</li> <li>c. Incident to a use or disclosure otherwise permitted or required by 45 CFR §164.502, provided that the MCE has complied with the applicable requirements of 45 CFR §§164.502(b), 164.514(d), and 164.530(c).</li> <li>d. Except for uses and disclosures prohibited under 45 CFR §164.502(a)(5)(i), pursuant to and in compliance with a valid authorization under 45 CFR §164.508.</li> <li>e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Business associate agreement template</li> <li>• One example of an executed business associate agreement</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 4, 5, 7 Minimum Necessary Requirements Policy Pg. 1-2</li> <li>• 5 Business Associate Agreement Policy and Procedure Pg. All</li> <li>• 5, 9 Authorizations and Consent Policy Pg. All</li> <li>• 4, 5 Safeguards Policy Pg. All</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g).</p> <p style="margin-left: 40px;">45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2</p>	<ul style="list-style-type: none"> <li>• 5 Disclosure to Third Parties Policy and Procedure Pg. All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Business associate agreement template:</u></b></p> <ul style="list-style-type: none"> <li>• 5 Vendor BAA Dec 2024 w_RISC Pg. All</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>4 5 7 Minimum Necessary Requirements Policy</u></b> Healthy Blue Associates may only collect, use and disclose the minimum amount of Protected Health Information (PHI) necessary to perform job functions.</p> <p><b><u>5 Business Associate Agreement Policy and Procedure</u></b> Healthy Blue must enter a Business Associate Agreement (BAA) with individuals and entities that meet the HIPAA definition of Business Associate.</p> <p><b><u>5 Authorizations and Consent Policy</u></b> Individuals can provide written authorization to disclose their Personally Identifiable Information (PII) for activities not related to Treatment, Payment or Health Care Operations.</p> <p><b><u>4 5 Safeguards Policy</u></b> Healthy Blue Associates are required to safeguard both paper and electronic forms of PHI, confidential and proprietary information.</p>		



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Requirement	Supporting Documentation	Score
<p><b>5 Disclosure to Third Parties Policy and Procedure</b> Healthy Blue (or its Business Associates) may disclose the minimum amount of Personally Identifiable Information (PII) without the Individual’s Authorization to perform Treatment, Payment and Health Care Operations (TPO).</p> <p><b>5 Vendor BAA Dec 2024 w RISC:</b> Healthy Blue must enter a Business Associate Agreement (BAA) with individuals and entities that meet the HIPAA definition of Business Associate.</p> <p><b>2_4_5_6_7_8_9_10_11_12_13_24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24:</b> All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p>Healthy Blue strictly follows HIPAA standards to protect PHI, using or disclosing it only as allowed by 45 CFR §164.502 and 45 CFR §160 subpart C. We disclose PHI to individuals and for treatment, payment, or healthcare operations per 45 CFR §164.506. Incidental uses or disclosures follow strict safeguards as outlined in 45 CFR §§164.502(b), 164.514(d), and 164.530(c). We also obtain valid authorizations per 45 CFR §164.508 when necessary and comply with permissions under 45 CFR §164.510. Additionally, our practices ensure compliance with 45 CFR §164.512 and §164.514(e), (f), and (g) for other essential functions. This commitment ensures the privacy and security of PHI.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI:</p> <p style="margin-left: 20px;">a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528.</p> <p style="margin-left: 20px;">b. When required by the Secretary to investigate or determine the MCE’s compliance with 45 CFR §160 subpart C.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.502(a)(2-4) 45 CFR §164.524</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Staff training materials</li> <li>Business associate agreement template</li> <li>One example of an executed business associate agreement</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b> <b><u>Policies and procedures:</u></b></p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">45 CFR §164.528 42 CFR §457.1110(d) 45 CFR §160 Subpart C</p> <p>MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> <li>6, 11-13 _ Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure Pg. 1-2 / 14 / All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>2-13 24 ANTH_04 DO THE RIGHT THING_enUS Full Script 17Dec24 Pg.6 / All</li> </ul> <p><b><u>Business associate agreement template:</u></b></p> <ul style="list-style-type: none"> <li>Standard 9_Element 2_3_Vendor BAA Dec 2024 w_RISC</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>6 11-13 Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure:</u></b> Individuals have the right to Access to inspect and/or obtain a copy of their PHI contained in a Designated Record Set (DRS); Accounting of non-Treatment, Payment, and Health Care Operations disclosures; and Amend PHI they believe is incorrect or inaccurate contained in a DRS. The dedicated Member Privacy Unit pulls the Access requests for Healthy Blue members.</p> <p><b><u>2 4 5 6 7 8 9 10 11 12 13 24 ANTH 04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b> All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>6 Vendor BAA Dec 2024 w RISC:</u></b> Healthy Blue must enter a Business Associate Agreement (BAA) with individuals and entities that meet the HIPAA definition of Business Associate. Healthy Blue strictly follows regulations for disclosing PHI. We comply with 45 CFR §164.524 and §164.528 by providing individuals access to their medical records upon request. We also disclose necessary information to the Secretary to ensure compliance with 45 CFR §160 subpart C. Our business associate agreements align with these standards, ensuring all disclosures are legal and transparent, thereby protecting our members' privacy rights.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
<b>Minimum Necessary</b>		
<p>7. When using or disclosing PHI or when requesting PHI from another covered entity or business associate, the MCE makes reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.</p> <p style="text-align: right;">45 CFR §164.502(b) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Three examples of requests for PHI from another covered entity (e.g., member’s previous MCE, dental benefits administrator, provider)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 4, 5, 7 Minimum Necessary Requirements Policy Pg. All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec2417Dec24Pg. 6 / All</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• MPU Peer 2 Peer audit and Liaison tracker for 2024</li> <li>• MPU Peer Reviews Monitoring DTP</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> <b><u>4 5 7 Minimum Necessary Requirements Policy</u></b> Healthy Blue Associates may only collect, use and disclose the minimum amount of Protected Health Information (PHI) necessary to perform job functions</p>		



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<p><b>2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24:</b> All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p>Healthy Blue adheres to the "minimum necessary" standard by ensuring only essential PHI is used, disclosed, or requested. We train our workforce regularly and implement strict policies and access controls. Monitoring and audits help enforce these practices, thereby protecting individual privacy and maintaining regulatory compliance.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>8. Minimum necessary does not apply to:</p> <ul style="list-style-type: none"> <li>a. Disclosures to or requests by a health care provider for treatment.</li> <li>b. Uses or disclosures made to the individual.</li> <li>c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508.</li> <li>d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160.</li> <li>e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a).</li> <li>f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502.</li> </ul> <p style="text-align: right; margin-right: 20px;">           45 CFR §164.502(b)(2)            45 CFR §164.508            45 CFR §164.512(a)            45 CFR Part 160            42 CFR §457.1110         </p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><u><b>Policies and procedures:</b></u></p> <ul style="list-style-type: none"> <li>• 8a -f Specialized Disclosures - Required by Law_ Abuse and Neglect_ Law Enforcement_ Judicial and Administrative P&amp;P Pg. All</li> <li>• 8a-f Specialized Disclosures - Government Functions_ Research_ Workers’ Compensation P&amp;P Pg. All</li> <li>• 8a-f Access to Protected Health Information (PHI), Amendment, and Accounting of Disclosures Policy and Procedure</li> <li>• 8a -f Specialized Disclosures - Averting Threat_ Public Health_ Health Oversight Policy and Procedure Pg. All</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
PIHP Contract: HIPAA Business Associate Addendum	<p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>2-13, 24 ANTH_04 DO THE RIGHT THING enUS_Full Script_17Dec24 Pg.6 / All</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>8 a b c d e f Specialized Disclosures - Required by Law Abuse and Neglect Law Enforcement Judicial and Administrative Policy and Procedure:</u></b>            Healthy Blue Associates are permitted to make certain Disclosures which may not require member authorization when Required by Law, for Victims of Abuse, Neglect or Domestic Violence, Judicial and Administrative Releases, and Law Enforcement purposes outside of Treatment, Payment, and Healthcare Operations (TPO).</p> <p><b><u>8 a b c d e f Specialized Disclosures - Government Functions Research Workers Compensation Policy and Procedure:</u></b>            Healthy Blue Associates are permitted to make certain Disclosures which may not require member authorization when Required by Law, for Victims of Abuse, Neglect or Domestic Violence, Judicial and Administrative Releases, and Law Enforcement purposes outside of Treatment, Payment, and Healthcare Operations (TPO).</p> <p><b><u>8 a b c d e f Specialized Disclosures - Averting Threat Public Health Health Oversight Policy and Procedure:</u></b>            Healthy Blue Associates are permitted to make certain Disclosures which may not require member authorization when Required by Law, for Victims of Abuse, Neglect or Domestic Violence, Judicial and Administrative Releases, and Law Enforcement purposes outside of Treatment, Payment, and Healthcare Operations (TPO).</p> <p><b><u>2-13, 24 ANTH 04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b>            All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p>Healthy Blue adheres to the "minimum necessary" principle by limiting access, use, or disclosure of PHI to only what is necessary for the intended purpose. However, this standard does not apply in certain situations, such as when healthcare providers request information for treatment, individuals request their own PHI, disclosures are made with proper authorization under 42 CFR §164.508, disclosures are made to the Secretary for compliance and investigations under 45 CFR Part 160, or when required by law or regulatory compliance under 45 CFR §164.512(a) and §164.502. These exceptions ensure seamless care coordination, individual access to health information, compliance with legal and regulatory requirements, and effective oversight by authorities.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



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Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
Use and Disclosures Requiring Authorizations		
<p>9. Except as otherwise permitted or required by 45 CFR Part 164 Subpart E, a covered entity may not use or disclose PHI without a valid authorization. When a covered entity obtains or receives a valid authorization for its use or disclosure of PHI such use or disclosure must be consistent with such authorization.</p> <p>a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization.</p> <p style="text-align: right;">45 CFR §164.508(a)(1) 45 CFR §164.508(b)(1-6) 45 CFR §164.508(c)(1-4) 45 CFR Part 164 Subpart E 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Authorization for use and disclosure form template</li> <li>• Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 5, 9 Authorization and Consent Policy Pg. 1 / All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 02-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Authorization for use and disclosure form:</u></b></p> <ul style="list-style-type: none"> <li>• 9 Member Auth Form Pg. All</li> </ul> <p><b><u>Authorization Examples:</u></b></p> <ul style="list-style-type: none"> <li>• 9 Examples of Authorizations Pg. All</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><b><u>5 9 Authorizations and Consent Policy</u></b></p> <p>Individuals can provide written authorization to disclose their Personally Identifiable Information (PII) for activities not related to Treatment, Payment or Health Care Operations.</p>		



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Requirement	Supporting Documentation	Score
<p><b>2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24:</b> All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>9 Member Auth Form:</u></b> Individuals can provide written authorization to disclose their Personally Identifiable Information (PII) for activities not related to Treatment, Payment or Health Care Operations.</p> <p><b><u>9 Examples of Authorizations:</u></b> Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 Uses and disclosures for which an authorization is required.</p> <p>Healthy Blue follows 45 CFR Part 164 Subpart E by using or disclosing PHI only with valid authorization, except where otherwise permitted or required by law. We ensure that any authorization obtained from an individual meets all regulatory standards and provide them with a copy of the signed authorization. This ensures transparency and aligns our actions with the individual’s consent, maintaining the privacy and security of their health information.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Privacy Rights		
<p>10. The MCE complies with the member’s right to request privacy protection for PHI and the requirements under 45 CFR §164.522.</p> <p style="text-align: right;">45 CFR §164.522 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Process workflow</li> <li>• Member request form for privacy protection</li> <li>• Two examples of member’s request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 10 Right to Request Restrictions Policy and Procedure Pg. All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Process workflow:</u></b></p> <ul style="list-style-type: none"> <li>• 10 Process Workflow Documentation Pg. All</li> </ul> <p><b><u>Member request form for privacy protection:</u></b></p> <ul style="list-style-type: none"> <li>• 10 Restriction Form Pg. All</li> </ul> <p><b><u>Privacy protection example:</u></b></p> <ul style="list-style-type: none"> <li>• 10 Privacy Protection Examples Pg. All</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>10 Right to Request Restrictions Policy and Procedure:</u></b> Individuals have a right to request that Wellpoint Restrict certain information. The dedicated Member Privacy Unit pulls the works the restriction requests for Wellpoint members.</p> <p><b><u>2-13, 24 ANTH_04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b> All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>10 Process Workflow Documentation:</u></b> Process workflow and tracking documentation.</p> <p><b><u>10 Restriction Form:</u></b></p>		



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<p>Individuals have a right to request that Wellpoint Restrict certain information.</p> <p><b>10 Privacy Protection Examples:</b> Examples of member’s request for privacy protection</p> <p>Healthy Blue strictly follows 45 CFR §164.522, respecting members' rights to request privacy protections for their PHI. We offer ways for members to restrict certain uses and disclosures of their PHI, particularly if services are fully paid out-of-pocket. Additionally, we facilitate confidential communications to ensure members can specify preferred methods or locations for receiving health information. Our commitment is reinforced through clear policies, regular staff training, and robust data protection systems to safeguard member privacy.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. The MCE complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.</p> <p style="margin-left: 20px;">a. The MCE acts on a request for access no later than 30 days after receipt of the request.</p> <p style="margin-left: 20px;">b. The MCE provides the member with access to the PHI in the form and format requested by the member, if it is readily producible in such form and format, or if not, in a readable hard copy form or such other form and format as agreed to by the MCE and member.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.524 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Staff training materials</li> <li>Process workflow</li> <li>Member request form to access PHI</li> <li>Two examples of member’s request to access PHI, including documentation of the request and evidence to support timely completion of the PHI access request</li> </ul> <p><b>Evidence as Submitted by the MCE:</b> <b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>6, 11-13 Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure Pg. 6 / All</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b></p> <p><b><u>6 11-13 Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure:</u></b>            Individuals have the right to Access to inspect and/or obtain a copy of their PHI contained in a Designated Record Set (DRS); Accounting of non-Treatment, Payment, and Health Care Operations disclosures; and Amend PHI they believe is incorrect or inaccurate contained in a DRS. The dedicated Member Privacy Unit pulls the Access requests for Healthy Blue members.</p> <p><b><u>2-13, 24 ANTH 04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b>            All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>11 13 Process Workflow:</u></b>            Process workflow and tracking documentation.</p>	<p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Process workflow:</u></b></p> <ul style="list-style-type: none"> <li>• 11, 13 Process Workflow &amp; Tracking Documentation Pg. All</li> </ul> <p><b><u>Member request form to access PHI:</u></b></p> <ul style="list-style-type: none"> <li>• 11 Access to Records form Pg. All</li> </ul> <p><b><u>Examples of member’s request to access PHI &amp; documentation:</u></b></p> <ul style="list-style-type: none"> <li>• 11 Examples of Access requests Pg. All</li> </ul>	



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p><b><u>11 Access to Records form:</u></b> An Access to Records form is a document used by individuals to formally request access to their PHI maintained by a healthcare provider, health plan, or other covered entity.</p> <p><b><u>11 Examples of Access requests:</u></b> Example of member’s request to access PHI and emails showing request was completed by sending to the mailroom. Healthy Blue adheres to 45 CFR §164.524 by acting on requests for access to PHI within 30 days. We ensure members can access their PHI in their desired format if it's readily producible. If not, we provide a readable hard copy or another agreed-upon format. This process upholds members' rights and ensures transparent access to their health information.</p> <p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p> <p><b>Required Actions:</b> No action required.</p>		
<p>12. The MCE complies with the member’s right to have the MCE amend PHI or a record about the member in a designated record set for as long as the PHI is maintained in the designated record set. The MCE complies with the requirements under 45 CFR §164.526.</p> <ul style="list-style-type: none"> <li>• The MCE acts on the member’s request for an amendment no later than 60 days after receipt of such a request.</li> </ul> <p style="text-align: right; margin-right: 50px;">45 CFR §164.526 42 CFR §457.1110(e)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Process workflow</li> <li>• Member request form to amend PHI</li> <li>• Two examples of member’s request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request</li> <li>• One example of a denial of an amendment and notification to the member</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 6, 11-13_Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure Pg. 15, 19</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Process workflow:</u></b></p> <ul style="list-style-type: none"> <li>• 12 Process Workflow Tracking Documentation Pg. All</li> </ul> <p><b><u>Member request form to amend PHI:</u></b></p> <ul style="list-style-type: none"> <li>• 12 Amendment Records Form Pg. All</li> </ul> <p><b><u>Amend PHI example:</u></b></p> <ul style="list-style-type: none"> <li>• 12 Amendment of PHI examples Pg. All</li> </ul> <p><b><u>Denial of amendment:</u></b></p> <ul style="list-style-type: none"> <li>• 12_Denial of Amendment Pg. All</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>6 11-13 Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure:</u></b>            Individuals have the right to Access to inspect and/or obtain a copy of their PHI contained in a Designated Record Set (DRS); Accounting of non-Treatment, Payment, and Health Care Operations disclosures; and Amend PHI they believe is incorrect or inaccurate contained in a DRS. The dedicated Member Privacy Unit pulls the Access requests for Healthy Blue members.</p> <p><b><u>2-13, 24 ANTH_04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b>            All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>12 Process Workflow:</u></b>            Process workflow and tracking documentation.</p>		



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<p><b><u>12 Amendment Records Form:</u></b> Member request form to amend PHI.</p> <p><b><u>12 Examples of Amend PHI:</u></b> Examples of request to amend PHI.</p> <p><b><u>12 Denial of Amendment:</u></b> Example of a denial of an amendment and notification to the member.</p> <p>Healthy Blue fully complies with 45 CFR §164.526, respecting our members' rights to amend their Protected Health Information (PHI) within a designated record set. We ensure that all amendment requests are addressed promptly, acting on them within 60 days of receipt, as long as the PHI is maintained in the designated record set. This commitment reflects our dedication to maintaining accurate records and upholding the privacy and rights of our members.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>13. The MCE complies with the member’s right to receive an accounting of disclosures of PHI made by the MCE in the six years prior to the date on which the accounting is requested, in compliance with the requirements under 45 CFR §164.528.</p> <p style="margin-left: 20px;">a. The MCE acts on the member’s request for an accounting, no later than 60 days after receipt of such a request.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> <li>• Process workflow</li> <li>• Member request form for an accounting of disclosures of PHI</li> <li>• Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure)</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j).</p> <p style="text-align: right;">45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> <li>Two examples of member’s request for an accounting of disclosures, including documentation of the request and evidence to support timely completion of the accounting of disclosure request</li> <li>Documentation to demonstrate how the record of the accounting of disclosures is retained</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>6 11-13_Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure Pg. 2, 13 / All</li> </ul> <p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>2-13, 24 ANTH_04 DO THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Process workflow &amp; Mechanism to track disclosures:</u></b></p> <ul style="list-style-type: none"> <li>11, 13 Process Workflow &amp; Tracking Documentation Pg. All</li> </ul> <p><b><u>Member request form for an accounting of disclosures of PHI:</u></b></p> <ul style="list-style-type: none"> <li>13 Accounting Disclosures Form Pg. All</li> </ul> <p><b><u>Accounting of disclosures example and retention:</u></b></p> <ul style="list-style-type: none"> <li>13 Accounting of Disclosures &amp; Retention Pg. All</li> </ul>	



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Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b>		
<p><b><u>6 11 12 13 Access to Protected Health Information (PHI), Amendments, and Accounting of Disclosure Policy and Procedure:</u></b>            Individuals have the right to Access to inspect and/or obtain a copy of their PHI contained in a Designated Record Set (DRS); Accounting of non-Treatment, Payment, and Health Care Operations disclosures; and Amend PHI they believe is incorrect or inaccurate contained in a DRS. The dedicated Member Privacy Unit pulls the Access requests for Healthy Blue members.</p> <p><b><u>2 4 5 6 7 8 9 10 11 12 13 24 ANTH 04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b>            All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>11 13 Process Workflow &amp; Tracking Documentation:</u></b>            Process workflow and tracking &amp; mechanism to track disclosures.</p> <p><b><u>13 Accounting Disclosures Form:</u></b>            Member request form for an accounting of disclosures of PHI.</p> <p><b><u>13 Accounting of Disclosures:</u></b>            Example of accounting of disclosures.             Healthy Blue ensures the privacy of members' PHI by adhering to 45 CFR §164.528. We respect members' rights to an accounting of disclosures made by our MCO over the past six years. Upon receiving such a request, we respond within 60 days as required. Additionally, we document all disclosures and retain this information as mandated by 45 CFR §164.530(j). These practices demonstrate our commitment to transparency and privacy protection.</p>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



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Requirement	Supporting Documentation	Score
<b>Breach of Unsecured PHI</b>		
<p>14. The MCE, following the discovery of a breach of unsecured PHI, notifies each individual whose unsecured PHI has been, or is reasonably believed by the MCE to have been accessed, acquired, used, or disclosed as a result of such breach.</p> <p style="margin-left: 20px;">a. Breach and unsecured PHI are as defined in 45 CFR §164.402.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.402 45 CFR §164.404(a)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Breach notification letter template</li> <li>Incident risk assessment tool</li> <li>Unauthorized disclosure/breach tracking mechanism</li> <li>List of all breaches of unsecured PHI during the time period under review, including the date of discovery and the date of notification to members</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>14-23_Incident Response and Reporting P&amp;P Pg. 1-2 / All</li> </ul> <p><b><u>Breach notification letter template:</u></b></p> <ul style="list-style-type: none"> <li>14_17_Breach Notification Template Pg. All</li> </ul> <p><b><u>Incident risk analysis tool:</u></b></p> <ul style="list-style-type: none"> <li>14_15_Incident Risk Assessment Tool_Redacted Pg. All</li> </ul> <p><b><u>Breach tracking mechanism:</u></b></p> <ul style="list-style-type: none"> <li>14_15_Compliance 360 Tracker_Redacted Pg. All</li> </ul> <p><b><u>List of breaches:</u></b></p> <ul style="list-style-type: none"> <li>14_15_16_22_23_Breach List Pg. All</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;P:</u></b> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>14 17 Breach Notification Template</u></b> Breach notification letter template.</p> <p><b><u>14 15 Incident Risk Assessment Tool Redacted:</u></b> Breach Notification Risk Assessment Tool.</p> <p><b><u>14 15 Compliance 360 Tracker Redacted:</u></b> Until April 2025, all incident management and documentation were handled through Compliance C360. Starting in April 2025, we have transitioned to using Radar First for efficient management and tracking of incidents.</p> <p><b><u>14-16 22 23 Breach List:</u></b> List of breaches. Healthy Blue strictly follows the standards in 45 CFR §164.402 for breaches of unsecured PHI. When a breach is discovered, our MCO promptly investigates and notifies all affected individuals. This notification occurs quickly and within the legal timeframe, detailing the breach, the types of PHI involved, recommended protective steps, our mitigation efforts, and contact information for assistance. This process ensures transparency, patient privacy protection, and regulatory compliance.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>15. The MCE for the purposes of 45 CFR §164.404(a)(1), 45 CFR §164.406(a), and 45 CFR §164.408(a), a breach is treated as discovered by the MCE as of the first day on</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Incident risk assessment tool</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>



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<p>which such breach is known to the MCE, or, by exercising reasonable diligence would have been known to the MCE.</p> <p>a. The MCE shall be deemed to have knowledge of a breach if such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is a workforce member or agent of the MCE.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<ul style="list-style-type: none"> <li>• Unauthorized disclosure/breach tracking mechanism</li> <li>• List of all breaches of unsecured PHI during the time period under review, including the date of discovery</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 14-23_Incident Response and Reporting P&amp;P Pg 10. / All</li> </ul> <p><b><u>Incident risk analysis tool:</u></b></p> <ul style="list-style-type: none"> <li>• 14_15_Incident Risk Assessment Tool_Redacted Pg. All</li> </ul> <p><b><u>Breach tracking mechanism:</u></b></p> <ul style="list-style-type: none"> <li>• 14_15_Compliance 360 Tracker_Redacted Pg. All</li> </ul> <p><b><u>List of breaches:</u></b></p> <ul style="list-style-type: none"> <li>• 14-16, 22, 23_Breach List Pg. All</li> </ul> <p><b><u>Additional Documentation:</u></b></p> <ul style="list-style-type: none"> <li>• Narrative response</li> </ul>	<input type="checkbox"/> NA
<p><b>MCE Description of Process:</b>  <b><u>14-23 Incident Response and Reporting P&amp;P:</u></b>            Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p>		



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<p><b><u>14 15 Incident Risk Assessment Tool Redacted:</u></b> Breach Notification Risk Assessment Tool.</p> <p><b><u>14 15 Compliance 360 Tracker Redacted:</u></b> Until April 2025, all incident management and documentation were handled through Compliance C360. Starting in April 2025, we have transitioned to using Radar First for efficient management and tracking of incidents.</p> <p><b><u>14-16, 22, 23 Breach List:</u></b> List of breaches.</p> <p>Healthy Blue complies with 45 CFR §164.404(a)(1), §164.406(a), and §164.408(a) by rigorously detecting and reporting breaches. We count a breach as discovered from the first day it is known or should have been known through diligence. All workforce members and agents are trained to identify and report unauthorized access immediately. Once reported, our privacy and compliance team investigates promptly. This ensures that any breach known to any workforce member, other</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>16. Except as provided in 45 CFR §164.412, the MCE must provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of such a breach.</p> <p style="text-align: right; margin-right: 20px;">45 CFR §164.404(b) 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members</li> <li>Three examples of breach notification letters to members</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> <li>14-23_Incident Response and Reporting P&amp;P Pg. 14 / All</li> </ul> <p><b>List of breaches:</b></p> <ul style="list-style-type: none"> <li>14-16, 22.23_Breach List Pg. All</li> </ul> <p><b>Breach notification letter examples:</b></p> <ul style="list-style-type: none"> <li>16_17_Breach Notification Member Letters LA_Redacted Pg. All</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narrative response</li> </ul>	
<p><b>MCE Description of Process:</b>  <b>14-23 Incident Response and Reporting P&amp;P:</b>            Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b>14-16, 22, 23 Breach List:</b>            List of breaches.</p> <p><b>16 17 Breach Notification Member Letters LA Redacted:</b>            Examples of breach notification letters.            Healthy Blue is dedicated to protecting members' PHI and responds promptly if a data breach occurs. We provide clear notifications detailing the breach date, discovery date, and the types of unsecured PHI involved, such as names, social security numbers, and diagnoses. We advise individuals on steps to protect themselves and describe our efforts to investigate, mitigate harm, and prevent future breaches. We offer multiple contact options, including a toll-free number, email, website, and postal address, for further inquiries. Our commitment is to ensure transparency, trust, and protection for our members' health information.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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<p>17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible:</p> <p>a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.</p> <p>b. A description of the types of unsecured PHI that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved).</p> <p>c. Any steps individuals should take to protect themselves from potential harm resulting from the breach.</p> <p>d. A brief description of what the MCE is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches.</p> <p>e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, web site, or postal address.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(c)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Breach notification letter template</li> <li>• Reading grade level of breach notification letter template</li> <li>• Three examples of breach notification letters to members</li> <li>• One example of notification to media outlet, if applicable during the review period</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 14-23_Incident Response and Reporting P&amp;P Pg. 14 / All</li> <li>• Standard 9_Element 14_Medicaid and Medicare</li> <li>• Privacy Incident Reporting All States DTP. 2025_Redacted Pg. All</li> </ul> <p><b><u>Breach notification letter template:</u></b> 14_17_Breach Notification Template</p> <ul style="list-style-type: none"> <li>• Pg. All</li> </ul> <p><b><u>Breach notification letter template reading level:</u></b></p> <ul style="list-style-type: none"> <li>• 17_Breach Notification Template Reading Level</li> </ul> <p><b><u>Breach notification letter examples:</u></b></p> <ul style="list-style-type: none"> <li>• 16_17_Breach Notification Member Letters</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> <li>LA_Redacted</li> <li>Pg. All</li> </ul> <p><b><u>Media Notice:</u></b> 17_Media Notice Pg. All</p> <p><b><u>Additional Documentation:</u></b></p> <ul style="list-style-type: none"> <li>External Communications Policy</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;P:</u></b> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>Standard 9 Element 14 Medicaid and Medicare Privacy Incident Reporting All States DTP. 2025 Redacted</u></b> All incident response associates must refer to the Medicaid and Medicare Privacy Incident Reporting DTP in the management of privacy incidents</p> <p><b><u>14 17 Breach Notification Template</u></b> Breach notification letter template.</p> <p><b><u>17 Breach Notification Template Reading Level:</u></b> Breach notification letter template reading level.</p> <p><b><u>16 17 Breach Notification Member Letters LA Redacted:</u></b> Examples of breach notification letters.</p> <p><b><u>17 Media Notice:</u></b> Media notice.</p> <p>Healthy Blue prioritizes the security of PHI and ensures timely notification in the event of a data breach. We clearly outline what happened, including the dates of the breach and its discovery, and specify the types of PHI involved, such as names, social security numbers, and addresses. We advise affected individuals on protective steps and detail our ongoing efforts to investigate, mitigate harm, and prevent future</p>		



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breaches. For additional information or questions, we provide multiple contact options: a toll-free number, email, website, and postal address. This ensures individuals are well-informed and supported throughout the process.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>18. The notification must be provided in the following form:</p> <ol style="list-style-type: none"> <li>a. Written notice by first-class mail to the individual at the last known address of the individual or, if the individual agrees to electronic notice and such agreement has not been withdrawn, by electronic mail.</li> <li>b. If the MCE knows the individual is deceased and has the address of the next of kin or personal representative of the individual, written notification by first-class mail to either the next of kin or personal representative of the individual.</li> <li>c. The notification may be provided in one or more mailings as information is available.</li> </ol> <p style="text-align: right;">45 CFR §164.404(d)(1)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Confirmation of first-class mailing</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><u><b>Policies and procedures:</b></u></p> <ul style="list-style-type: none"> <li>• 14-23 Incident Response and Reporting P&amp;P Pg. 14 / All</li> </ul> <p><u><b>Confirmation of first-class mailing:</b></u></p> <ul style="list-style-type: none"> <li>• No applicable</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><u><b>14-23 Incident Response and Reporting P&amp;P:</b></u> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><u><b>Standard 9 Element 15 First Class Mailing:</b></u> Not applicable</p>		



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<p>Healthy Blue is committed to adhering to the notification requirements outlined in the regulation. In the event of a breach involving unsecured PHI, we ensure that affected individuals receive written notice by first-class mail to their last known address. If the individual has opted for electronic communication and has not withdrawn their consent, the notification will be sent via email instead. In circumstances where the MCO is aware that the individual is deceased and has the contact details of the next of kin or personal representative, we will provide written notification by first-class mail to them. Moreover, we recognize the need for timely communication and may send notifications in multiple mailings as more information becomes available. This structured approach ensures that all affected parties are promptly and adequately informed, thereby maintaining compliance with regulatory requirements and upholding our commitment to protecting the privacy and security of PHI.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>19. In the case in which there is insufficient or out-of-date contact information that precludes written notification to the individual, a substitute form of notice reasonably calculated to reach the individual must be provided.</p> <p style="margin-left: 20px;">a. If there is insufficient or out-of-date contact information for fewer than 10 individuals, then such notice may be provided by an alternative form of written notice, telephone, or other means.</p> <p style="margin-left: 20px;">b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must:</p> <p style="margin-left: 40px;">i. Be in the form of either a conspicuous posting for a period of 90 days on the home page of the MCE’s website, or conspicuous notice in major print or broadcast media in geographic areas where the individuals affected by the breach likely reside.</p> <p style="margin-left: 40px;">ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period</li> <li>One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>14-23_Incident</li> <li>Response and Reporting P&amp;P Pg. 14 / All</li> </ul> <p><b><u>Substitute Notice Examples:</u></b></p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p>whether the individual’s unsecured PHI may be included in the breach.</p> <p>c. Substitute notice need not be provided in the case in which there is insufficient or out-of-date contact information that precludes written notification to the next of kin or personal representative of the individual under 45 CFR §164.404(d)(1)(ii).</p> <p style="text-align: right;">45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b><u>One example of a substitute notice for when there was insufficient or out-of-date contact information for fewer than 10 members, if applicable during the review period</u></b></p> <ul style="list-style-type: none"> <li>• Not applicable</li> </ul> <p><b><u>One example of a substitute notice for when there was insufficient or out-of-date contact information for more than 10 members, if applicable during the review period</u></b></p> <ul style="list-style-type: none"> <li>• 19_Substitute Notice Pg. All</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Evidence of remediation conducted with vendor that reported breach (Vimarc) beyond required timeframes</li> </ul>	
<p><b>MCE Description of Process:</b>  <b><u>14-23 Incident Response and Reporting P&amp;P:</u></b>            Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>19 Substitute Notice:</u></b>            Incident happened in 2023, but the vendor did not tell us about the incident until 2024. This is the notice we put on our Healthy Blue website in 2024.</p> <p>Healthy Blue ensures prompt notification of breaches involving unsecured PHI, even when contact information is insufficient or outdated. For fewer than 10 individuals, we use alternative methods such as written notice, phone calls, or other means. For 10 or more individuals, we post a conspicuous notice on our website for 90 days or in major media where affected individuals likely reside, including a toll-free number active for 90 days. If next of kin or personal representatives cannot be contacted due to insufficient information, substitute notice is not required per 45 CFR §164.404(d)(1)(ii). These steps ensure compliance with regulations while effectively informing affected individuals.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



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<b>Required Actions:</b> No action required.		
<p>20. In any case deemed by the MCE to require urgency because of possible imminent misuse of unsecured PHI, the covered entity may provide information to individuals by telephone or other means, as appropriate, in addition to notice provided under 45 CFR §164.404(d)(1).</p> <p style="text-align: right;">45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• One example of notice provided to members for an urgent situation, if applicable during the review period</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 14-23_Incident Response and Reporting P&amp;P Pg. 15 / All</li> </ul> <p><b><u>One example of notice provided to members for an urgent situation, if applicable during the review period:</u></b></p> <ul style="list-style-type: none"> <li>• Not applicable</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;P:</u></b> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>One example of notice provided to members for an urgent situation, if applicable during the review period:</u></b> Not applicable, process outlined in P&amp;P. Healthy Blue takes the privacy and security PHI very seriously and adheres to the standards set forth in 45 CFR §164.404(d)(1) and related regulations. In cases where the Managed Care Organization MCO determines that there might be an imminent misuse of unsecured PHI, we adopt a proactive approach. This involves promptly informing affected individuals not only through the standard written notice but also via</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<b>Required Actions:</b> No action required.		



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<p>21. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the MCE must, following the discovery of the breach, notify prominent media outlets serving the State or jurisdiction, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.406(a-b)</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• One example of breach of unsecured PHI involving more the 500 members, including the date of discovery and date of notification to media outlets, if applicable during the review period</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 14-23_Incident</li> <li>• Response and Reporting P&amp;P Pg. 15 / All</li> </ul> <p><b><u>Breach involving more than 500 members:</u></b></p> <ul style="list-style-type: none"> <li>• 21_No Breaches of More than 500 LA Medicaid Pg. All</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;PP:</u></b> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>21 No Breaches of More than 500 LA Medicaid:</u></b> No breach involving more than 500 members</p> <p>Our health plan is committed to strict compliance with privacy and security regulations regarding PHI. In the event of a breach affecting more than 500 residents of a State or jurisdiction, our protocol is to promptly assess and identify the scope of the breach. Following this assessment, we notify the relevant prominent media outlets serving the affected area without unreasonable delay, ensuring that this is completed no later than 60 calendar days after the breach is discovered. By adhering to these timelines, we maintain transparency and uphold our commitment to</p>		



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safeguarding our members' personal information. Additionally, we follow up with appropriate actions to mitigate any potential harm and to strengthen our security measures to prevent future breaches.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary.</p> <p>a. For breaches of unsecured PHI involving 500 or more individuals, the MCE must, except as provided in 45 CFR §164.412, provide the notification contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site.</p> <p>b. For breaches of unsecured PHI involving less than 500 individuals, the MCE must maintain a log or other documentation of such breaches and, not later than 60 days after the end of each calendar year, provide the notification for breaches discovered during the preceding calendar year, in the manner specified on the HHS web site.</p> <p style="text-align: right;">45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members</li> <li>• Annual notification to HHS of breaches of unsecured PHI, including the date of notification</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <p><u><b>Policies and procedures:</b></u></p> <ul style="list-style-type: none"> <li>• 14-23_Incident</li> <li>• Response and Reporting P&amp;P Pg. 15 / All</li> </ul> <p><u><b>List of breaches:</b></u></p> <ul style="list-style-type: none"> <li>• 14-16, 22. 23_Breach List Pg. All</li> </ul> <p><u><b>HHS notification:</b></u></p> <ul style="list-style-type: none"> <li>• 22_VIMARC Baesman HHS Redacted Pg. All</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;P:</u></b> Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents</p> <p><b><u>14-16, 22, 23 Breach List:</u></b> List of breaches.</p> <p><b><u>22 VIMARC Baesman HHS Redacted:</u></b> HHS breach notification.</p> <p>Healthy Blue adheres to the regulatory requirements for reporting breaches of unsecured PHI as detailed in 45 CFR §164.408. In case of a breach involving 500 or more individuals, we ensure that the Secretary is notified contemporaneously with the notice required by 45 CFR §164.404(a) and follow the procedures outlined on the HHS website. For breaches affecting fewer than 500 individuals, we meticulously maintain a log to document all incidents and ensure that notifications for breaches discovered during the preceding calendar year are submitted no later than 60 days after the calendar year's end, in accordance with the specifications provided on the HHS website. This systematic approach ensures compliance and diligent reporting of all PHI breaches, safeguarding our commitment to data privacy and regulatory adherence.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>23. The MCE must require its business associates (i.e., subcontractors) to, following the discovery of a breach of unsecured PHI, notify the MCE of such breach.</p> <p>a. A breach shall be treated as discovered by a business associate as of the first day on which such breach is known to the business associate or, by exercising reasonable diligence, would have been known to the business associate. A business associate shall be deemed</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• List of breaches of unsecured PHI reported by subcontractors</li> <li>• One example of executed business associate agreement</li> <li>• One example of executed subcontractor contract</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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<p>to have knowledge of a breach if the breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer, or other agent of the business associate.</p> <p>b. Except as provided in 45 CFR §164.412, the MCE must require a business associate to provide the notification without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.</p> <p>c. The notification must include, to the extent possible, the identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, accessed, acquired, used, or disclosed during the breach.</p> <p>d. The MCE must require a business associate to provide the MCE with any other available information that the MCE is required to include in notification to the individual under 45 CFR §164.404(c) at the time of the notification or promptly thereafter as information becomes available.</p> <p style="text-align: right;">45 CFR §164.404(c) 45 CFR §164.410 45 CFR §164.412</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <p><b><u>Policies and procedures:</u></b></p> <ul style="list-style-type: none"> <li>• 14-23_Incident</li> <li>• Response and Reporting P&amp;P Pg. 10, 23 / All</li> </ul> <p><b><u>List of subcontractor breaches:</u></b></p> <ul style="list-style-type: none"> <li>• 14-16, 22, 23_Breach List Pg. All</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>14-23 Incident Response and Reporting P&amp;P:</u></b></p> <p>Healthy Blue has the responsibility to investigate, mitigate and respond to incidents involving possible privacy and security incidents.</p>		



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p><b>14-16, 22, 23 Breach List:</b> List of subcontractor breaches.</p> <p>Healthy Blue ensures compliance with regulatory requirements for managing and reporting breaches of unsecured PHI through meticulous protocols. We establish clear BAAs with all business associates, mandating them to report any breaches immediately upon discovery or when they should have reasonably known, in line with regulatory expectations. Breaches must be reported to us without undue delay and within 60 calendar days. Notifications provided by our business associates must include the identification of affected individuals and any additional information required for us to notify them, as per 45 CFR §164.404(c). We continuously monitor compliance and provide training to ensure understanding and adherence to these protocols, thereby safeguarding our members' health information.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Notice of Privacy Practices		
<p>24. The MCE’s members have a right to adequate notice of the uses and disclosures of PHI that may be made by the MCE, and of the member’s rights and the MCE’s legal duties with respect to PHI.</p> <p>a. The MCE provides a notice that is written in plain language and that contains the elements required by 45 CFR §164.520(b)(1).</p> <p>b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c).</p> <p style="text-align: right;">45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110</p> <p>MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Process for disseminating Notice of Privacy Practices</li> <li>• Staff training materials</li> <li>• Copy of Notice of Privacy Practices</li> <li>• Link to Notice of Privacy Practices on the MCE’s website</li> </ul> <p><b>Evidence as Submitted by the MCE:</b> <b><u>Policies and procedures &amp; Process for disseminating:</u></b></p> <ul style="list-style-type: none"> <li>• 24_ Notice Policy and Procedure Pg. 1, 6 / All</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<p><b><u>Staff training materials:</u></b></p> <ul style="list-style-type: none"> <li>• 2-13, 24 ANTH_04 DO</li> <li>• THE RIGHT THING_enUS_Full_Script_17Dec24 Pg.6 / All</li> </ul> <p><b><u>Copy of Notice of Privacy Practices:</u></b></p> <ul style="list-style-type: none"> <li>• 24_HIPAA Notice of Privacy Practices Pg. All</li> </ul> <p><b><u>Link to Notice of Privacy Practice:</u></b></p> <ul style="list-style-type: none"> <li>• <a href="#">Privacy   Healthy Blue Louisiana Medicaid</a></li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><u>24 Notice Policy and Procedure:</u></b></p> <p>Individuals have the right to receive a Notice of Privacy Practices (NOPP) from Healthy Blue’s Health Plans. This notice describes Healthy Blue’s Use and Disclosures of certain PHI. Additionally, certain Individuals have the right to receive a notice about PI rights under State Data Privacy Laws. These notices also outline Healthy Blue’s legal duties with respect to PHI and PI.</p> <p>There is an established process for disseminating the Notice of Privacy Practices to ensure individuals receive and have access to it as required.</p> <p><b><u>2-13, 24 ANTH_04 DO THE RIGHT THING enUS Full Script 17Dec24:</u></b></p> <p>All associates must complete our new hire and annual “Do the Right Thing” learning program.</p> <p><b><u>24 HIPAA Notice of Privacy Practices:</u></b></p> <p>Individuals have the right to receive a Notice of Privacy Practices (NOPP) from Healthy Blue’s Health Plans. This notice describes Healthy Blue’s Use and Disclosures of certain PHI. Additionally, certain Individuals have the right to receive a notice about PI rights under State Data Privacy Laws. These notices also outline Healthy Blue’s legal duties with respect to PHI and PI.</p>		



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>Regarding the reissue of the Notice of Privacy Practices (NOPP) due to regulatory updates. HIPAA requires reissue of NOPP upon material modification. If there is a material modification, Medicaid business area will be advised to send out new notice. Minor modifications do not require issuance of a new NOPP, but the most current version of the NOPP will be posted on applicable website(s). And if a member calls and requests a copy of the NOPP, they will be sent a copy that is posted on the website.</p> <p><a href="#">Privacy   Healthy Blue Louisiana Medicaid</a></p> <p>Healthy Blue is committed to ensuring that our members are well-informed about their privacy rights and the uses and disclosures of their PHI. We provide a comprehensive notice, written in plain language, that includes all the elements mandated by 45 CFR §164.520(b)(1). This notice is readily available to our members upon request, in full compliance with 45 CFR §164.520(c). We take our legal duties regarding the protection of PHI seriously and strive to maintain transparency with our members regarding their rights and our practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		

Results for Standard II—Member Rights and Confidentiality							
<b>Total</b>	Met	=	23	X	1	=	23
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	24	<b>Total Score</b>	=	23	

<b>Total Score ÷ Total Applicable</b>	=	<b>96%</b>
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## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Member Rights Checklist

Standard II—Member Rights Checklist		
Reference	Required Components	
A member enrolled with the MCE has the following rights:		
42 CFR §438.10 42 CFR §438.100(b)(2)(i) 42 CFR §457.1220  MCO Contract: 2.13.6.2.6; 2.14.8; MCO Manual PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.13.1.1.2	1. Receive information in accordance with 42 CFR §438.10.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Member Handbook pp 77, 81-88, 92-96</li> <li>No applicable additional documentation submitted to demonstrate how MCE disseminates materials in accordance with 42 CFR §438.10.</li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220  MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	2. Be treated with respect and with due consideration for his or her dignity and privacy.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Member Rights and Responsibilities – LA</li> <li>Care management records screenshot</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(iii) 42 CFR §457.1220  MCO Contract: 2.13.1.4.6; 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.4	3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Care team screenshot</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220  MCO Contract: 2.9.32. 1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Authorization detail screenshot</li> </ul>	
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220  MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Remedial action steps for seclusion complaint (screenshot)</li> </ul>	
42 CFR §438.100(b)(2)(vi) 42 CFR §457.122045 CFR Part 160 45 CFR Part 164, Subparts A and E 45 CFR §164.524 45 CFR §164.526  MCO Contract: 2.13.6.2.6; 2.13.6.6.3.11; MCO Manual PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: 5.13.1.1.9	6. If the privacy rule (as set forth in 45 CFR parts 160 and 164 subparts A and E) applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>No applicable additional documentation submitted.</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard II—Member Rights Checklist		
Reference	Required Components	
42 CFR §438.100(b)(3) 42 CFR §438.206 through §438.210 42 CFR §457.1220  MCO Contract: 2.4.1.2; 2.13.6.2.6; MCO Manual PAHP Contract: 2.4.1.4; 2.9.1.9 PIHP Contract: 5.13.1.1.14	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>No applicable additional documentation submitted.</li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(c) 42 CFR §457.1220  MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.15	8. Exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCE and its network providers or the State treat the member.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Care management note detail (screenshot)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(d) 42 CFR §438.3(d)(3)(4) 42 CFR §457.1220 45 CFR Part 80 45 CFR Part 91 Rehabilitation Act of 1973 Education Amendments of 1972, Title IX ADA, Titles II and III ACA, Section 1557  MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	9. The MCE shall comply with any other applicable federal and State laws (including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act (ADA), and section 1557 of the Patient Protection and Affordable Care Act (ACA).  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Provider and Member Bill of Rights pages 1 and 2 policy section</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>No applicable additional documentation submitted.</li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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**Standard III—Member Information**

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<b>Information Requirements</b>		
<p>1. The MCE provides all required information referenced in 42 CFR §438.10 to members and potential members in a manner and format that may be easily understood and is readily accessible by members and potential members.</p> <p><i>“Readily accessible” means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C’s Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.</i></p> <p><i>Note: LA reading grade level should be no higher than a 6.9 reading grade level for MCOs and PAHPs and no higher than a 5.0 reading grade level for the PIHP.</i></p> <p style="text-align: right;">42 CFR §438.10(c)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures</li> <li>• Member materials, such as the member handbook, provider directory, member notices, etc.</li> <li>• Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials)</li> <li>• Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01_Accessibility at Healthy Blue.pdf, page 1</li> <li>• Healthy Blue Member Handbook 12 23.pdf, page 14</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 1_Written Material Guidelines - LA .pdf</li> <li>• 1_Member Materials – Appropriateness.docx</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue assigns a writer copy editor for all member materials, including the web site. The writer/copy editor usually runs a grade level check of the copy doc and creates a grade level document using a Health Literacy Advisor tool in Word. This GRD doc is "stamped" with the grade level. The website is reviewed to ensure it meets the standards before publishing.</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>2. The MCE uses the definitions for managed care terminology developed by the State including:</p> <p style="margin-left: 20px;">a. Appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(c)(4)(i) 42 CFR §457.1207</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 80 - 81</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The MGE's appeals process ensures member rights:</p> <ul style="list-style-type: none"> <li><b>Filing Appeals:</b> Members can appeal service denials.</li> <li><b>Response:</b> Decision within 30 days; expedited in 72 hours if needed.</li> <li><b>Support:</b> Member Services available for guidance.</li> <li><b>Benefits Continuation:</b> Coverage can continue during appeals.</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li><b>State Fair Hearings:</b> Available if appeal outcome is unsatisfactory.</li> </ul> <p>This ensures a structured and responsive approach to member concerns.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL’s member handbook did not use definitions that aligned with State definitions.</p>		
<p><b>Required Actions:</b> The MCE must ensure the use of definitions for managed care terminology developed by the State.</p>		
<p>3. The MCE uses State-developed model member handbooks and member notices.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>The PIHP shall develop and maintain a Member Handbook, due to LDH at go-live, that adheres to the requirements in 42 CFR §438.10 and the written materials requirements.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures</li> <li>Member materials, such as the member handbook</li> <li>Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>03,04,07_Member Appeal Upheld Letter.pdf</li> <li>03,04,07_Member Appeal Partial Letter.pdf</li> <li>03,04,07_Member Appeal Overturn Letter.pdf</li> <li>03,04,07_Member Administrative Appeal Uphold Letter.pdf</li> <li>03,04,07_Grievance Ack Letter.pdf</li> <li>03,04,07_Grievance Resolution Letter.pdf</li> <li>LA ABD Notice Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> See attached grievance and appeal letters approved by the State.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<b>Language and Format</b>		
<p>4. The MCE makes its written materials that are critical to obtaining services, including at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its service areas.</p> <p>a. Written materials that are critical to obtaining services are also made available in alternative formats upon request of the member or potential member at no cost.</p> <p>b. Written materials that are critical to obtaining services include taglines in the prevalent non-English languages in the State and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.</p> <p>c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services.</p> <p>d. Written materials that are critical to obtaining services include the toll-free and TTY/TDD telephone number of the MCE’s member/customer services unit.</p> <p>e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.</p> <p style="text-align: right;">42 CFR §438.10(d)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.5 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider directory in English, including taglines</li> <li>Provider directory in prevalent non-English languages, including taglines</li> <li>Member handbook in English, including taglines</li> <li>Member handbook in prevalent non-English languages, including taglines</li> <li>Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices)</li> <li>Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines</li> <li>Definition of conspicuously visible font</li> <li>Mechanisms to ensure taglines are included as part of all critical member materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Standard III.4,15_Member Materials – Appropriateness.pdf</li> <li>03,04,07_Member Appeal Upheld Letter.pdf</li> <li>03,04,07_Member Appeal Partial Letter.pdf</li> <li>03,04,07_Member Appeal Overturn Letter.pdf</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>03,04,07_Member Administrative Appeal Uphold Letter.pdf</li> <li>03,04,07_Grievance Ack Letter.pdf</li> <li>03,04,07_Grievance Resolution Letter.pdf</li> <li>LA ABD Notice Letter</li> <li>Link to Spanish provider Directory <a href="https://espanol.myhealthyblue.com/la/care/find-a-doctor.html">https://espanol.myhealthyblue.com/la/care/find-a-doctor.html</a></li> <li>Link to Spanish Member Handbook <a href="https://www.myhealthyblue.com/la/lala_caid_mhb_spa.pdf">https://www.myhealthyblue.com/la/lala_caid_mhb_spa.pdf</a></li> <li>Link to Provider Directory in English <a href="https://www.myhealthyblue.com/la/care/find-a-doctor.html">https://www.myhealthyblue.com/la/care/find-a-doctor.html</a></li> <li>Link to Member handbook in English <a href="https://www.myhealthyblue.com/la/lala_caid_mhb_eng.pdf">https://www.myhealthyblue.com/la/lala_caid_mhb_eng.pdf</a></li> </ul> <p><b>Additional Documentation:</b> Supplied the same documentation and annotated the sections that show compliance to the federal regulation.</p> <ul style="list-style-type: none"> <li>4_Grievance Ack Letter.pdf</li> <li>4_Member Appeal Partial Letter.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> See the attached grievance and appeal letters showing how they are available in non-English languages, available to members needing interpretation or any other auxiliary aid. Also, links provided for the Spanish Provider Directory and Member handbook</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The letters submitted as evidence did not explicitly reference auxiliary aids and services, nor did the letters provide specific examples such as braille, large print, or sign language interpreters.</p>		
<p><b>Required Actions:</b> The MCE must update written materials that are critical to obtaining services to include information on how to request auxiliary aids and services.</p>		
<p>5. The MCE makes interpretation services available to each member free of charge.</p> <p style="margin-left: 20px;">a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL).</p> <p style="margin-left: 20px;">b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(d)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15.2 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Executed interpretation services (oral and written) contract(s)</li> <li>Workflow for obtaining oral interpretation services</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 13-14, 90</li> <li>05, 06_Oral Translation_ Intepretation Services.pdf</li> <li>05, 06_Linguistic and Translation Services</li> <li>05, 06_Use a Translator During a Member Call.pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue provides information on accessibility services as follows:</p> <ul style="list-style-type: none"> <li><b>Language Services:</b> Oral interpretation is available for all languages, and written translation services are offered for prevalent languages.</li> <li><b>Auxiliary Aids:</b> These are available upon request and at no cost for members with disabilities, including aids like qualified interpreters and assistive devices.</li> <li>Policy and procedure specific to Oral Translation and interpretation of services</li> </ul>		



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Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>6. The MCE notifies members:</p> <ul style="list-style-type: none"> <li>a. That oral interpretation is available for any language and written translation is available in prevalent languages;</li> <li>b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and</li> <li>c. How to access these services.</li> </ul> <p style="text-align: right; margin-right: 100px;">42 CFR §438.10(d)(5) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.3.2.4; 2.9.2.1.3.2.5 PIHP Contract: 5.6.1.5; 5.15.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, pages 13-14 and 90</li> <li>• 05, 06_Oral Translation_ Interpretation of services.pdf</li> <li>• 05, 06_Linguistic and Translation Services.pdf</li> <li>• 05, 06_Use a Translator During a Member Call.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 6,11_HBL_MemberHandbook.pdf</li> <li>• 6_Member Language Information.docx</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue provides information on accessibility services as follows:</p> <ul style="list-style-type: none"> <li>• <b>Language Services:</b> Oral interpretation is available for all languages, and written translation services are offered for prevalent languages.</li> <li>• <b>Auxiliary Aids:</b> These are available upon request and at no cost for members with disabilities, including aids like qualified interpreters and assistive devices.</li> <li>• <b>Access:</b> Members can easily access these services by contacting Member Services at 844-521-6941 (TTY 711). This ensures compliance with accessibility standards and support</li> </ul>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>Policy and procedure for oral translation and interpretation of services provided</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. While the member handbook stated members may contact member services if they need letters or information in another language, the verbiage did not clearly notify the member that written translation is available in prevalent languages.</p>		
<p><b>Required Actions:</b> The MCE must revise the member handbook to include language that notifies the member that written translation is available in prevalent languages.</p>		
<p>7. The MCE provides all written materials for potential members and members consistent with the following:</p> <ol style="list-style-type: none"> <li>Use easily understood language and format.</li> <li>Use a font size no smaller than 12 point.</li> <li>Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.</li> </ol> <p><i>“Limited English proficient (LEP)” means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.</i></p> <p style="text-align: right;">42 CFR §438.10(d)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.8; 2.14.8.1; 2.14.8.8 PAHP Contract: 2.9.2.1.3.2.3; 2.9.2.1.3.2.4 PIHP Contract: 5.6.1.1; 5.6.1.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member handbook</li> <li>Provider directory</li> <li>All member newsletters during the time period of review</li> <li>Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice</li> <li>Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials)</li> <li>Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services</li> <li>Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 13 and 18</li> <li><a href="#">lala_caid_membernewsletterfall_2024.pdf</a></li> <li>03,04,07_Member Appeal Upheld Letter.pdf</li> <li>03,04,07_Member Appeal Partial Letter.pdf</li> <li>03,04,07_Member Appeal Overturn Letter.pdf</li> <li>03,04,07_Member Administrative Appeal Uphold Letter.pdf</li> <li>03,04,07_Grievance Ack Letter.pdf</li> <li>03,04,07_Grievance Resolution Letter.pdf</li> <li>LA ABD Notice Letter</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue ensures all written materials are accessible and understandable by:</p> <ul style="list-style-type: none"> <li>Using clear language and a font size of at least 12 points.</li> <li>Offering materials in alternative formats and auxiliary aids at no cost, considering members with disabilities or limited English proficiency (LEP).</li> <li>Providing interpretation and translation services to support LEP members.</li> <li>Members can access these services through Member Services, ensuring compliance with accessibility standards.</li> <li>Provided the link to the Fall 2024 Member newsletter as well as uploaded the document.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<b>Information for Members</b>		
<p>8. The MCE makes a good faith effort to give written notice of termination of a contracted provider to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. Notice to the member must be provided by the later of:</p> <p style="margin-left: 20px;">a. Thirty calendar days prior to the effective date of the termination; or</p> <p style="margin-left: 20px;">b. Fifteen calendar days after receipt or issuance of the termination notice.</p> <p>PAHP:</p> <p style="margin-left: 20px;">a. The PAHP shall provide notice to an enrollee, who has been receiving a prior authorized course of treatment, when the treating provider becomes unavailable.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(f)(1) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.9.2 PAHP Contract: 2.6.11.4 PIHP Contract: 5.14.1.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Workflow of provider termination process</li> <li>Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members</li> <li>Two examples of provider-initiated terminations when the effective date of the termination is in the future, including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members</li> <li>Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members</li> <li>Tracking or reporting mechanism that demonstrates timeliness</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>8_Member Notification of Provider Termination.pdf</li> <li>8_Health Plan Initiated Term_Example 1.docx</li> <li>8_Member Notification of HP Initiated Term_Example 1.pdf</li> <li>8_Health Plan Initiated Term_Example 2.docx</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>8_Member Notification of HP Initiated Term_ Example 1.pdf</li> <li>8_Provider Notification of Future Term_ Example 1.msg</li> <li>8_Member Notification of Provider Future Term_ Example 1.pdf</li> <li>8_Provider Notification of Future Term_ Example 2.msg</li> <li>8_Member Notification of Provider Future Term_ Example 2.pdf</li> <li>8_Provider Notification of Retro Term_ Example 1.msg</li> <li>8_Member Notification of Provider Retro Term_ Example 1.pdf</li> <li>8_Provider Notification of Retro Term_ Example 2.msg</li> <li>8_Member Notification of Provider Retro Term_ Example 2.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Upon review, the PCP term letter submitted for Jimmy Kittrell was related to a separate termination event for the same provider. Please accept the attached letter, “III.8_Retro Term Letter_2024.08.14” as evidence for member notification following the retroactive termination of PCP Jimmy Kittrell. Because the member had care history with a different PCP the termination</li> </ul>	



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	triggered a move to the panel of the PCP of history and notification.	
<p><b>MCE Description of Process:</b> Healthy Blue ensures compliance with the requirement to provide written notice of provider terminations to affected members through a well-documented process incorporating various policies, procedures, workflows, and tracking mechanisms. Specifically, the document "Standard III.8_Member Notification of Provider Termination.pdf" outlines the MCE's policies and procedures by mandating timely member notification and reassignment. It requires that members be notified at least 30 calendar days before the termination effective date, or within 15 days after receiving a termination notice, thereby meeting the regulatory requirement. This document also illustrates the workflow for the termination process, detailing the steps from provider termination notice submission to member notification, and includes deadlines for different types of terminations, ensuring compliance with the defined timelines.</p> <p>To further exemplify these processes, the attached examples provide practical evidence of the policy in action. The documents "Standard III.8_Member Notification of HP Initiated Term_ Example 1.pdf" and "Standard III.8_Member Notification of HP Initiated Term_ Example 2.pdf" exhibit MCE-initiated provider terminations. These examples include the effective termination dates and member notices, thus demonstrating adherence to notification timelines and offering tangible proof of compliance. Similarly, two examples of provider-initiated terminations, where the termination date is set for the future, are demonstrated through "Standard III.8_Health Plan Initiated Term_ Example 1.msg" and "Standard III.8_Member Notification of Provider Future Term_ Example 1.pdf." These documents verify the notification process by including evidence of communication with both the provider and the affected members, ensuring members are informed in advance of the termination.</p> <p>For retroactive provider-initiated terminations, the documents "Standard III.8_Provider Notification of Retro Term_ Example 1.msg" and "Standard III.8_Member Notification of Provider Retro Term_ Example 1.pdf" serve as examples. They display the MCE's efforts to notify members swiftly, even when the effective termination date has passed, thus ensuring that members are informed promptly in accordance with the specified timelines.</p> <p>Lastly, the MCE incorporates a systematic tracking and reporting mechanism to demonstrate timeliness in member notifications. This mechanism is crucial for maintaining regulatory compliance and ensuring network adequacy, as evidenced by the consistent documentation across all the provided files. This comprehensive approach verifies that the MCE fulfills its obligations to notify members timely and effectively, thereby maintaining service continuity and member access to care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not support compliance with the requirements. The member notification regarding a provider termination was not within the required time frames.</p>		
<p><b>Required Actions:</b> The MCE must notify, in writing, each member who received his or her primary care from or was seen on a regular basis by a terminated provider. Notice to the member must be provided by the later of:</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>Thirty calendar days prior to the effective date of the termination; or</li> <li>Fifteen calendar days after receipt or issuance of the termination notice.</li> </ul>		
<p>9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i).</p> <p style="margin-left: 40px;">42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of physician incentive plans</li> <li>Example of physician incentive plan provided to a member upon request (if the MCE does not have physician incentive plans, please state so under the <i>MCE Description of Process</i>)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>09_Risk and Shared Savings Arrangement Management Policy.pdf</li> <li>09_List of Physician Incentive Plans.png</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue adheres to the requirements set forth in 42 CFR §438.3(i) by ensuring that any physician incentive plans in place are available upon request. This process is supported by policies and procedures designed to manage risk and shared savings arrangements effectively. Specifically, the "Standard III.9_Risk and Shared Savings Arrangement Management Policy.pdf" comprehensively outlines the applicable policies and procedural frameworks that govern how these incentive plans are established, executed, and monitored, ensuring compliance and transparency within the operational processes.</p> <p>Furthermore, the "Standard III.9_List of Physician Incentive Plans.png" provides a detailed list of all physician incentive plans implemented by the MCE, thereby satisfying the requirement to maintain a documented inventory of such plans. This document serves as a ready reference to demonstrate the range of incentive initiatives in place, showcasing Healthy Blue’s commitment to maintaining up-to-date and comprehensive records.</p> <p>As no members requested information on physician incentive plans in 2024, we currently do not have documented examples of providing such information to a member. However, the outlined procedures ensure that if a request were made, the MCE is fully equipped to provide the necessary details promptly and as required by regulation. This proactive stance ensures that compliance is maintained even in the absence of specific member inquiries, reflecting a robust framework for managing physician incentive plans.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
<b>Member Handbook</b>		
<p>10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE:</p> <ul style="list-style-type: none"> <li>a. Mails a printed copy of the information to the member’s mailing address;</li> <li>b. Provides the information by email after obtaining the member’s agreement to receive the information by email;</li> <li>c. Posts the information on the MCE’s website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or</li> <li>d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information.</li> </ul> <p>PAHP:</p> <ul style="list-style-type: none"> <li>a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled:               <ul style="list-style-type: none"> <li>i. A current enrollee handbook</li> </ul> </li> </ul> <p style="text-align: right;">42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.)</li> <li>• Member materials, such as member welcome packet</li> <li>• Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 10_16030686 1080320LAMENHBL GB NMP Welcome Guide MKT.docx</li> <li>• 10_New Member Materials Distribution.pdf</li> <li>• 10,12,13,19_Distribution of Materials - Producing Medicaid Marketing Materials.docx</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.3 PAHP Contract: 2.9.7.2; 2.9.8.1; 2.9.8.1.2 PIHP Contract: 5.8.3.3</p>		
<p><b>MCE Description of Process:</b> Healthy Blue communicates information to members by:</p> <ul style="list-style-type: none"> <li>• Mailing printed copies to the member's address.</li> <li>• Providing information via email with the members' consent.</li> <li>• Posting information on Healthy Blue's website and notifying members of its availability, with auxiliary aids for those unable to access it online.</li> <li>• Using alternative methods to ensure information delivery.</li> <li>• Printed materials, including handbooks, are provided within ten business days for new or re-enrolled members.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. The member handbook includes all requirements listed in the Member Handbook Checklist.</p> <p style="text-align: right;">42 CFR §438.10(g)(2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested)</li> <li>• Link to member handbook on MCE's website</li> <li>• HSAG will also use the results of the Member Handbook Checklist</li> </ul> <p><b>Evidence as Submitted by the MCE:</b> Searchable PDF of Member Handbook</p> <ul style="list-style-type: none"> <li>• Link to New Member Welcome information on web site: <a href="#">Medicaid   Healthy Blue Louisiana Medicaid</a></li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Link to Member Handbook on web site: <a href="#">Member Handbooks and Helpful Resources   Healthy Blue Louisiana Medicaid</a></li> <li>11_HBL StandardIII_MemberInformation_3.8.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>6_11_HBL_MemberHandbook.pdf               <ul style="list-style-type: none"> <li>– Timeframes grievance and appeals: page 79 of PDF</li> <li>– Availability of assistance: Pages 79 and 80 of PDF</li> <li>– Responsibilities: Pages 90 and 91 of PDF</li> <li>– SBHS: Pages 24, 47-59 of PDF                   <ul style="list-style-type: none"> <li>▪ Family Resilience: Pages 76 and 77 of PDF</li> <li>▪ Family/caregiver: 77-79 of PDF                       <ul style="list-style-type: none"> <li>• EBP: 54 of PDF</li> </ul> </li> <li>▪ Consent: Page 88 of PDF</li> </ul> </li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b> See Member Handbook and other evidence submitted by MCE</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not provide evidence of compliance with the requirements. HBL’s member handbook did not include the following language:</p> <ul style="list-style-type: none"> <li>The requirements and time frames for filing a grievance.</li> <li>The availability of assistance in the filing process for appeals.</li> <li>Information regarding specialized behavioral health services (SBHS), including, but not limited to:               <ul style="list-style-type: none"> <li>– 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;</li> </ul> </li> </ul>		



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Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>– Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and</li> <li>– 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.</li> </ul>		
<p><b>Required Actions:</b> The MCE must include the following language in the member handbook:</p> <ul style="list-style-type: none"> <li>• The requirements and time frames for filing a grievance.</li> <li>• The availability of assistance in the filing process for appeals.</li> <li>• Information regarding SBHS, including, but not limited to:               <ul style="list-style-type: none"> <li>– 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;</li> <li>– Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and</li> <li>– 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.</li> </ul> </li> </ul>		
<p>12. The MCE gives each member notice of any change to the member handbook that the State defines as significant in the information specified in the member handbook, at least 30 days before the intended effective date of the change.</p> <p><i>Note: LA defines significant as “important in effect or meaning.”</i></p> <p style="text-align: right;">42 CFR §438.10(g) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Workflow for member handbook changes</li> <li>• One example of a change to the member handbook due to a significant change and notice sent to members (if there were no significant changes during the past 12 months, state so in the <i>MCE Description of Process</i>)</li> <li>• Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 10,12,13,19_Distribution of Materials - Producing Medicaid Marketing Materials.docx, pages 1 and 2</li> <li>• Welcome letter sent to Members after change to PBM in 2024</li> <li>• Redlined Update to Handbook and Welcome Kit for significant change</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue adheres to a policy of notifying members of any changes to the member handbook that the state of Louisiana defines as significant—meaning important in effect or meaning—at least 30 days before the change's effective date. This process ensures members are well-informed in advance about adjustments that may impact their benefits or plan details.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Provider Directory		
<p>13. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist.</p> <p style="text-align: right;">42 CFR §438.10(h)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.6.4 PAHP Contract: 2.9.8.3.1; 2.9.8.1.4 PIHP Contract: 5.8.3.1; 5.10.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand)</li> <li>• Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable)</li> <li>• Link to the online provider directory</li> <li>• HSAG will also use the results of the Provider Directory Checklist</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 10,12,13,19_Distribution of Materials - Producing Medicaid Marketing Materials.docx, pages 1 and 2</li> <li>• Member Facing provider directory</li> <li>• Link to online provider directory: <a href="http://myhealthyblue.com/la/lala_caaid_providerdirectory.pdf">myhealthyblue.com/la/lala_caaid_providerdirectory.pdf</a></li> </ul> <p><b>Additional Documentation:</b></p> <p>Directories:</p> <ul style="list-style-type: none"> <li>• 13_LA Behavioral Health Directory.pdf</li> <li>• 13_LA Medicaid Directory.pdf</li> </ul> <p>Evidence of Electronic Directory:</p> <ul style="list-style-type: none"> <li>• Standard III 13 14 LA CAID – BH Area of Expertise – 9-5-2025.docx</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue makes the provider directory available to members on the website. The MCE makes the provider directory available in paper form upon request and electronic form. The provider directory must include the information from the Provider Directory Checklist.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p> <p><b>Recommendations:</b> HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>14. Information included in the MCE’s paper provider directory is updated at least:</p> <p style="margin-left: 20px;">a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or</p> <p style="margin-left: 20px;">b. Quarterly, if the MCE has a mobile-enabled electronic provider directory.</p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.</i></p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.10(h)(3)(i) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4; 2.13.8.4 PAHP Contract: 2.9.2.1.2.2; 2.9.2.1.2.3 PIHP Contract: 5.10.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Verification of a mobile-enabled electronic provider directory</li> <li>Workflow for updating paper provider directories</li> <li>Three consecutive provider directory update examples, including the dates for when the updates were made</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>14,15_Provider Directories.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Standard III 13 14 LA CAID – BH Area of Expertise – 9-5-2025.docx</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The Provider Directory policy was provided to outline how the provider directories are handled. Healthy Blue also has an online mobile directory available to all members.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>15. Information included in the MCE’s electronic provider directory is updated no later than 30 calendar days after the MCE receives updated provider information.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. The web-based online version shall be updated in real time, but no less than weekly.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Workflow for updating the electronic provider directory</li> <li>Three consecutive provider directory update examples, including evidence to demonstrate the date the MCE was made aware of the updated</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>PAHP:</p> <p>a. In accordance with 42 CFR §438.10(h), the PAHP must develop and implement an online provider directory, to be approved by LDH. The directory shall be interactive and user friendly, web-based machine searchable, web-based machine readable, and mobile-enabled. It must be accurate, complete and updated no less than once weekly.</p> <p style="text-align: right;">42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.4 PAHP Contract: 2.9.2.1.2.1; 2.9.2.1.2.1 PIHP Contract: 5.10.3</p>	<p>provider information and the date the change was reflected in the electronic provider directory</p> <ul style="list-style-type: none"> <li>Tracking mechanisms to demonstrate timeliness</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>14,15_Provider Directories.pdf</li> <li>15_LACAID - PLM P-5367670 - E2E Screenshot.docx</li> <li>15_LACAID - PLM P-5456316 - E2E Screenshot.docx</li> <li>15_LACAID - PLM P-6046673 - E2E Screenshot.docx</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s process for maintaining compliance with the updating of its electronic provider directory is rooted in strict adherence to a structured protocol that ensures updates are meticulously and promptly executed. The document "Standard III.15_Provider Directories.pdf" lays the foundation by detailing the policies and procedures that govern the updates, ensuring that all changes to provider information are reflected within 30 calendar days upon receipt of updated information. These guidelines are further complemented by a well-defined workflow that actively involves the Health Plan’s Provider Relations teams and the Demographic Data Operations (DDO) team, ensuring a seamless transition of accurate data into the source system.</p> <p>The documents provided demonstrate compliance through specific examples and evidence. Three consecutive examples, namely "Standard III.15_LACAID - PLM P-5367670 - E2E Screenshot.docx," "Standard III.15_LACAID - PLM P-5456316 - E2E Screenshot.docx," and "Standard III.15_LACAID - PLM P-6046673 - E2E Screenshot.docx," offer a clear illustration of the MCE's adherence to timing requirements. These examples show the precise dates when new provider information was received and when the updates were executed within the electronic directory, validating that the MCE meets the 30-calendar day requirement.</p> <p>Moreover, the ongoing maintenance and compliance with the MCE's obligations include regular updates to the web-based version of the directory, ensuring it is refreshed in real-time but no less than weekly, particularly for Managed Care Organizations (MCOs).</p> <p>Lastly, the policies describe robust tracking mechanisms that further corroborate timeliness in updates. These mechanisms are indispensable for internal audits and quality assurance practices, capturing every phase from knowledge of the update through to its reflection in the directory. This meticulous documentation and implementation of processes ensure that the provider directory is not only current and compliant but also enhances accessibility and usability for all stakeholders.</p>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>16. The MCE’s provider directory is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.10(h)(4) 42 CFR §457.1207</p> <p>MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Confirmation of machine-readable provider directory (e.g., .JSON format)</li> <li>Link to the publicly available machine-readable provider directory on the MCE’s website</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Find a Doctor   Healthy Blue Louisiana Medicaid</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Please see link for Healthy Blue’s provider directory.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Formulary		
<p>17. The MCE makes available in electronic, or paper form the following information about its formulary:</p> <p style="margin-left: 20px;">a. Which medications are covered (both generic and name brand).</p> <p style="margin-left: 20px;">b. What tier each medication is on.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.10(i)(1-2) 42 CFR §457.1207</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Copy of formulary in Word or PDF format (excerpts are acceptable)</li> <li>Link to the publicly available formulary on the MCE’s website</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Pharmacy Information   Healthy Blue Louisiana</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Formulary is linked here on the Healthy Blue website: <a href="#">Pharmacy Information   Healthy Blue Louisiana</a>. The link takes you to a PDF of the formulary (<a href="#">PDL.pdf</a>). Prime is the PBM and not the MCO.</p>		
<p><b>HSAG Findings:</b> The State contracted with a single Pharmacy Benefits Manager (PBM) for the Louisiana Medicaid managed care program; therefore, HSAG has determined that this requirement is not applicable. However, the MCE did provide a link on its website to a formulary that the single PBM maintained.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>18. The MCE’s formulary drug list is made available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p> <p style="text-align: right;">42 CFR §438.10(i)(3) 42 CFR §457.1207</p> <p>MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Confirmation of machine-readable formulary (e.g., .JSON format)</li> <li>• Link to the publicly available machine-readable formulary on the MCE’s website</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• HBL's pharmacy page: at <a href="#">PDL.pdf</a>.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Please see link to the pharmacy with the PDL included.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Electronic Materials and Communications		
<p>19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following:</p> <ol style="list-style-type: none"> <li>a. The format is readily accessible.</li> <li>b. The information is placed in a location on the MCE’s website that is prominent and readily accessible.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures</li> <li>• Workflow for disseminating member materials</li> <li>• List of all materials that are only provided electronically</li> <li>• Link to the MCE’s homepage of its website</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Information		
Requirement	Supporting Documentation	Score
<p>c. The information is provided in an electronic form which can be electronically retained and printed.</p> <p>d. The information is consistent with the content and language requirements of 42 CFR §438.10.</p> <p>e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.</p> <p style="text-align: right;">42 CFR §438.10(c)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7</p>	<ul style="list-style-type: none"> <li>Tracking mechanisms related to requests for information in paper form that includes the date of the member’s request and the date it was provided to the member (e.g., mailed)</li> <li>Evidence for how members are informed that paper copies of information are available upon request and without charge</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>10,12,13,19_Distribution of Materials - Producing Medicaid Marketing Materials.docx, pages 1 and 2</li> <li>Link to homepage: <a href="#">Home   Healthy Blue Louisiana Medicaid</a></li> <li>Healthy Blue Member Handbook 12 23.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>19_HBL Website.docx</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue complies by providing member information electronically, ensuring it is readily accessible and prominently placed on the website, available in formats that can be retained and printed, consistent with content and language requirements. Members are informed they can request paper copies at no charge, which are provided within five business days</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. While HBL’s website included language informing the member that information is available in other formats, the language was not specific to information being available in paper form without charge upon request and that the MCE provides it upon request within five business days.</p>		
<p><b>Required Actions:</b> The MCE must inform members on the website that information provided electronically is available in paper form without charge upon request and provide it upon request within five business days.</p>		



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Results for Standard III—Member Information						
<b>Total</b>	Met	=	12	X	1	= 12
	Not Met	=	6	X	0	= 0
	Not Applicable	=	1			
<b>Total Applicable</b>		=	18	<b>Total Score</b>	=	12

<b>Total Score ÷ Total Applicable</b>	=	<b>67%</b>
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## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Member Handbook Checklist

Standard III—Member Handbook Checklist		
Reference	Required Components	
The content of the member handbook includes information that enables the member to understand how to effectively use the managed care program. This information includes at a minimum:		
42 CFR §438.10(g)(2)(i) 42 CFR §457.1207  MCO Contract: 2.13.6.2.7; 2.13.6.2.26; 2.13.6.2.26 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	1. Benefits provided by the MCE.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 26 – 42 section “Your Healthcare Benefits”</li> </ul>	
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207  MCO Contract: 2.13.6.2.8; 2.13.6.2.14 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11; 5.9.2.13	2. How and where to access any benefits provided by the State.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 26 – 42 section “Your Healthcare Benefits”</li> </ul>	
42 CFR §438.10(g)(2)(ii) 42 CFR §457.1207  MCO Contract: 2.13.6.2.24 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.27	3. How transportation is provided.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 17 under the section titled "Important phone numbers" and on page 32 under the section titled "Medical transportation services.</li> </ul>	
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207  MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf page 73 section titled Your Rights</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207  MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf page 73 section titled Your Rights</li> </ul>	
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207  MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled.  <i>For the MCOs, this also includes specialized behavioral health benefits and information about health education and promotion programs, including Care Management, tobacco cessation, and problem gaming.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf page 26 – 42</li> <li>Healthy Blue Member Handbook 12 23.pdf Page 46-53,</li> </ul>	
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207  MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.  <i>The PIHP must also include procedures for plan of care development.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> Page 18: In the "Your Providers" section, which provides information about service authorizations and accessing specialty care. <ul style="list-style-type: none"> <li>Page 21: The "Specialists" section explains the process of seeing a specialist and any necessary authorizations.</li> <li>Page 26: The "Your covered services" section offers details about covered services and benefits.</li> <li>Page 58: Discusses the requirement for prior authorizations under "Prior Authorizations."</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207  MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf page 90 and page 3</li> </ul>	
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207  MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, page 4</li> </ul>	
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207  MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf page four emergency section</li> <li>• Healthy Blue Member Handbook 12 23.pdf, page 63</li> </ul>	
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207  MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, page 4</li> </ul>	
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member’s freedom of choice among network providers.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, page 20</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(vii) 42 CFR §457.1207  MCO Contract: 2.13.6.2.10 PAHP Contract: 2.9.7.2 PIHP Contract: None	13. The extent to which, and how, members may obtain benefits, including family planning services and supplies from out-of-network providers. This includes an explanation that the MCE cannot require members to obtain a referral before choosing a family planning provider.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 20</li> </ul>	
42 CFR §438.10(g)(2)(viii) 42 CFR §457.1207  MCO Contract: 6.36.1 PAHP Contract: 6.17.1 PIHP Contract: NA	14. Cost sharing (if any imposed under the State plan).	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf ,pages 73 and 74</li> </ul>	
42 CFR §438.10(g)(2)(ix) 42 CFR §438.100 42 CFR §457.1207  MCO Contract: 2.13.6.2.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.6	15. Member rights and responsibilities, including the elements specified in 42 CFR §438.100.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 87-90</li> </ul>	
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207  MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member’s primary care provider/primacy dental provider.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 32 -33</li> </ul>	
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207	17. The right to file grievances and appeals.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 79 - 80</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1		
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207	18. The requirements and timeframes for filing a grievance or appeal.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 79 - 81</li> </ul>	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207	19. The availability of assistance in the filing process for grievances and appeals.	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 80 - 82</li> </ul>	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207	20. The right to request a state fair hearing (SFH) (or a State external review for the Children’s Health Insurance Program [CHIP]) after the MCE has made a determination on a member's appeal which is averse to the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 80 - 81</li> </ul>	
42 CFR §438.10(g)(2)(xi)(E)  MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 82-83</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xii) 42 CFR §438.3(j)(3)  MCO Contract: 2.13.6.2.19; 2.13.6.2.19.1-2.13.6.2.19.4 PAHP Contract: NA PIHP Contract: 5.9.2.19	22. How to exercise an advance directive, as set forth in 42 CFR §438.3(j) <i>The MCOs must provide a description of advance directives which includes:</i> <i>The MCO's policies related to advance directives;</i> <i>The enrollee's rights under State Law, including the 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 Healthy Blue Member Handbook 12 23.pdf as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;</i> <i>Information on how enrollees can file complaints about the failure to comply with an advance directive with the LDH Health Standards Section, Louisiana's Survey and Certification agency; and</i> <i>Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 75-76</li> </ul>	
42 CFR §438.10(g)(2)(xiii) 42 CFR §457.1207  MCO Contract: 2.13.6.2.31 PAHP Contract: 2.9.7.2 PIHP Contract: 5.6.1.5; 5.9.2.29	23. How to access auxiliary aids and services, including additional information in alternative formats or languages. <i>For the MCO, this instruction shall be included in all versions of the Healthy Blue Member Handbook 12 23.pdf in English and Spanish.</i> <i>For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 13-14</li> </ul>	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207  MCO Contract: 2.13.6.2.22; 2.13.6.2.23	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 101</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21		
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207	25. Information on how to report suspected fraud or abuse.	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 19 and 92</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	26. <i>The MCOs must include a description on the purpose of the Medicaid ID Card and the MCO Member ID Card and why both are necessary and how to use them.</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 19</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	27. <i>The MCOs must include information on how to call the Medicaid Customer Service Unit toll-free hotline, visit the Louisiana Medicaid Program website, or visit a regional Louisiana Medicaid Program eligibility office to report any changes to demographic or other information which may affect eligibility;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 13 and 19</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	28. <i>The MCOs must include information on how to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 24 and 26</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.28 PAHP Contract: NA PIHP Contract: NA	29. <i>The MCOs must include information about the requirement that an Enrollee shall notify the Contractor immediately if he or she has a Worker's Compensation claim, a pending personal injury or medical malpractice lawsuit, or has been involved in an automobile accident;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 87</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	30. <i>The MCOs must include reporting requirements for the Enrollee that has or obtains another health insurance policy, including employer sponsored insurance. Such situations shall be reported to the Contractor;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 58 - 59</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.30 PAHP Contract: NA PIHP Contract: NA	31. <i>The MCOs must include enrollee responsibilities, appropriate and inappropriate behavior, and any other information deemed essential by the Contractor or LDH. This shall include a statement that the Enrollee is responsible for protecting their MCO Member ID Card and that misuse of the card, including loaning, selling or giving it to others could result in loss of the Enrollee's Louisiana Medicaid Program eligibility and/or legal action;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 18 and 84.</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.35 PAHP Contract: NA PIHP Contract: NA	32. <i>The MCOs must include the date of the last revision;</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Member Pp. 1 and 99</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	33. <i>The MCOs must include Information regarding SBHS, including, but not limited to:</i> <ol style="list-style-type: none"> <li>a. <i>A description of covered behavioral health services;</i></li> <li>b. <i>Where and how to access behavioral health services and behavioral</i></li> </ol>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Member Handbook Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	<i>health providers;</i> c. <i>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;</i> d. <i>Description of the family/caregiver or legal guardian role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families; and</i> e. <i>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.</i>	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 8; 24, 45-46; 48-52; 56-57; 94</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	34. <i>The PIHP must include CSoC eligibility requirements;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 56</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	35. <i>The PIHP must include Member’s Bill of Rights;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 84</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	36. <i>The PIHP must include where to find medical necessity criteria on the Contractor’s website and how to request hardcopies of medical necessity criteria;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 18 and 27</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.20	37. <i>The PIHP must include how to make, change, and cancel appointments and the importance of canceling and/or rescheduling rather than being a “no-show;”</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, pages 22, 24, 47, 62 -65, 67-68, 70-72</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. <i>The PIHP must include family’s/caregiver’s or legal guardian’s role in the assessment, treatment, and support for individuals with an emphasis on promoting engagement, resilience, and the strengths of individuals and families;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 56</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. <i>The PIHP must include generic information on the treatment of behavioral health conditions and the principles of adult, family, child, youth and young adult’s engagement, resilience, strength-based and evidence-based practice, and best/proven practices;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf ,pages 45 and 57</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. <i>The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 12</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. <i>The PIHP must include 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;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 94</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.26	42. <i>The PIHP must include how to identify and contact the WAAs and FSO;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. <i>The PIHP must include names, locations, telephone numbers of, and non-English languages spoken by current network providers including identification of providers that are not accepting new patients. This may be a summary of information with reference to the website of the Contractor where an up-to-date listing is maintained and details on using the web-based provider directory;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 58</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. <i>The PIHP must include the date of the last revision;</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 1</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. <i>The PIHP must include the mechanism by which a member may submit, whether oral or in writing, a service authorization request for the provision of services; and</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Healthy Blue Member Handbook 12 23.pdf, page 166</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	<p>46. <i>The PIHP must include additional information that is available upon request, including the following:</i></p> <ul style="list-style-type: none"> <li>a. <i>Information on the structure and operation of the Contractor;</i></li> <li>b. <i>Pharmacy location or medication information availability;</i></li> <li>c. <i>Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and</i></li> <li>d. <i>Service utilization policies</i></li> </ul>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Healthy Blue Member Handbook 12 23.pdf, pages 42, 306, 329, 356,</li> </ul>	



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### Provider Directory Checklist

Standard III—Provider Directory Checklist		
Reference	Required Components	
The MCE makes available in paper form upon request and searchable electronic form, the following information about its network providers:		
42 CFR §438.10(h)(1)(i) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	1. The provider’s name as well as any group affiliation.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 29)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(1)(ii) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	2. Street address(es).  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 29)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(1)(iii) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	3. Telephone number(s).  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 29)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207	4. Website Uniform Resource Locator (URL), as appropriate.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	<ul style="list-style-type: none"> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 35)</li> </ul>	
42 CFR §438.10(h)(1)(v) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	5. Specialty, as appropriate.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 29)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(1)(vi) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1	6. Whether the provider will accept new members.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 1)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	7. The provider’s cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider’s office.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 40)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Provider Directory Checklist		
Reference	Required Components	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207  MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider’s office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Standard Iib_2024 Provider Directory Screenshots.docx</li> <li>Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 1)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(h)(2) 42 CFR §457.1207  MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: <ol style="list-style-type: none"> <li>Physicians, including specialists;</li> <li>Hospitals;</li> <li>Pharmacies;</li> <li>Behavioral health providers;</li> </ol> The MCO provider directory components are included for the following provider types <i>and shall be delineated by parish and zip code:</i> <ol style="list-style-type: none"> <li>Hospital primary care physician (PCP) groups</li> <li>Clinic settings</li> <li>Home and community-based services</li> <li>Outpatient therapy</li> <li>Residential substance use</li> <li>Youth residential services</li> <li>Inpatient mental health and residential substance use services</li> <li>Federally qualified health centers (FQHCs)</li> <li>Rural health clinics (RHCs)</li> <li>Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.</li> <li>Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.</li> <li>Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.</li> </ol>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Provider Directory Checklist		
Reference	Required Components	
	<p>The PAHP provider directory components are included for the following provider types:</p> <ol style="list-style-type: none"> <li>a. <i>Endodontists</i></li> <li>b. <i>Maxillofacial surgeons</i></li> <li>c. <i>Oral surgeons</i></li> <li>d. <i>Orthodontists</i></li> <li>e. <i>Pedodontists</i></li> <li>f. <i>Periodontists</i></li> <li>g. <i>Prosthodontists</i></li> <li>h. <i>Special needs pedodontists</i></li> </ol>	
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Standard Iib_BLA-LAHB 014614-22 LA Medicaid 0224 Final.pdf (Pg. 1, 44, 884, 885, 886, 913, 975)</li> </ul>	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	<p>10. <i>The PAHP provider directory must include the following:</i></p> <ol style="list-style-type: none"> <li>a. <i>The provider’s cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;</i></li> <li>b. <i>Office hours;</i></li> <li>c. <i>Specific performance indicators;</i></li> <li>d. <i>A statement that some providers may choose not to perform certain services based on religious or moral beliefs;</i></li> </ol>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• NA</li> </ul>	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	<p>11. <i>The PAHP Provider Directory must also include the following:</i></p> <ol style="list-style-type: none"> <li>a. <i>Providers arranged by name in alphabetical order</i></li> <li>b. <i>Showing the provider’s specialty,</i></li> <li>c. <i>Providers listed by specialty in alphabetical order by name.</i></li> </ol>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• NA</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard III—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5, 5.10.4.6	<p>12. <i>The PIHP Provider Directory must include the following:</i></p> <ol style="list-style-type: none"> <li>a. <i>Indication of populations served by the provider (e.g., age range of clients) and specialties;</i></li> <li>b. <i>Identification of any restrictions on the member’s freedom of choice among providers;</i></li> <li>c. <i>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);</i></li> <li>d. <i>Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.</i></li> </ol>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Standard Iib _BLA-LAHB 014812-22 LA Behavioral Health 0224 Final.pdf (Pg. 6, 25, 259)</li> </ul>	



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Standard IV—Emergency and Poststabilization Services**

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<b>Definitions</b>		
<p>1. The MCE defines “emergency medical condition” as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <p style="margin-left: 20px;">a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.</p> <p style="margin-left: 20px;">b. Serious impairment to bodily functions.</p> <p style="margin-left: 20px;">c. Serious dysfunction of any bodily organ or part.</p> <p style="margin-left: 100px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Standard IV_Healthy Blue Provider Manual_2023.pdf, page 131</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 2</li> <li>Member handbook page 62</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> MCE’s process for defining an "emergency medical condition" is thoroughly outlined in the provider manual, ensuring that it aligns with the regulatory requirement by detailing the criteria for such conditions based on acute symptoms that pose a serious risk without immediate medical intervention. The definition encompasses scenarios where a prudent layperson would expect potential jeopardy to health, serious impairment of bodily functions, or dysfunction of an organ, especially in the context of pregnant women and their unborn children. The "Standard IV_Healthy Blue Provider Manual_2023.pdf" satisfies the element by providing comprehensive guidance and definitions that ensure providers are informed and compliant with the requirement. This manual serves as a critical resource, clearly articulating the applicable definitions and protocols necessary for immediate recognition and response to emergency medical conditions, thus verifying the MCE’s adherence to required health and safety standards.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
<p>2. The MCE defines “emergency services” as covered inpatient and outpatient services that are as follows:</p> <p style="margin-left: 20px;">a. Furnished by a provider that is qualified to furnish these services under Title 42.</p> <p style="margin-left: 20px;">b. Needed to evaluate or stabilize an emergency medical condition.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(a) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7, Glossary and Acronyms PIHP Contract: Glossary</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Standard IV_Healthy Blue Provider Manual_2023.pdf, page 131</li> <li>Member handbook page 60</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 2</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The MCE’s process for defining "emergency services" is clearly articulated in the "Standard IV_Healthy Blue Provider Manual_2023.pdf," which satisfies the provider materials element by detailing how these services encompass both inpatient and outpatient care necessary for evaluating or stabilizing an emergency medical condition. The manual ensures that these services are furnished by providers qualified under Title 42, which is a critical component of compliance. It outlines the procedures for delivering timely and medically necessary interventions without requiring preauthorization, emphasizing the importance of immediate evaluation and stabilization of emergency conditions. Furthermore, the document thoroughly covers provider responsibilities, qualifications, and coordination protocols to guarantee that services align with regulatory requirements, thereby confirming the MCE's commitment to maintaining adherence and delivering quality emergency care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<b>Required Actions:</b> No action required.		
<p>3. The MCE defines “poststabilization care services” as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</p> <p style="text-align: right;">42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Standard IV_Healthy Blue Provider Manual_2023.pdf, page 44</li> <li>Healthy Blue Member Handbook page 90</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 3</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE’s process for defining “poststabilization care services” is thoroughly detailed in the “Standard IV_Healthy Blue Provider Manual_2023.pdf,” which satisfies the provider materials element by outlining that these services are covered when related to an emergency medical condition and required after a member is stabilized. The manual ensures compliance with 42 CFR §438.114I by specifying that such services are essential to maintain the member’s stabilized condition or improve or resolve the member’s condition when necessary. It provides comprehensive guidelines for the referral processes and roles of both primary and specialty care providers in coordinating appropriate post-stabilization care. Additionally, the manual underscores the importance of timely notifications and precertification for certain services post-emergency, ensuring that providers understand their compliance obligations and the protocols for delivering these critical services. This ensures that the MCE meets regulatory requirements while promoting continuity and quality of care after stabilization.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Coverage and Payment		
<p>4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE.</p> <p style="text-align: right;">42 CFR §438.114I(1)(i) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Standard IV_Healthy Blue Provider Manual_2023.pdf, pages 44, 131</li> <li>Healthy Blue Member Handbook page 62</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 3</li> <li>Claim logic in MCE Description of Process</li> <li>Three claim examples for emergency services including one OON provider               <ul style="list-style-type: none"> <li>– 4_Post Stabilization INN Clm 277371495600.docx</li> <li>– 4_Post Stabilization INN Clm 278038176100.docx</li> <li>– 4_Post Stabilization OON Clm 262861453301.docx</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b> The MCE demonstrates its commitment to covering and paying for emergency services, regardless of the provider's contractual status, as outlined in the "Standard IV_Healthy Blue Provider Manual_2023.pdf." This document satisfies the provider materials element by clearly stating that all emergency services are covered, ensuring timely access to care for members experiencing medical emergencies, even if the services are rendered by out-of-network providers. The manual details the necessary processes and guidelines ensuring compliance with federal regulations, emphasizing that emergency services are accessible to all members without barriers related to provider contract status. This policy reflects the MCE's dedication to ensuring that members receive critical care when needed, thereby fulfilling the requirement of equitable emergency services coverage.</p> <p>Claim logic for ER services is identified through Revenue Code(s) 045X for institutional claims and Place of Service 23 for professional services. Outpatient claims (Type of Bill-Class=13) with Revenue Code(s) 045X do not require authorization.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>5. The MCE does not deny payment for treatment obtained under either of the following circumstances:</p> <p style="margin-left: 20px;">a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of “emergency medical condition.”</p> <p style="margin-left: 20px;">b. A representative of the MCE instructs the member to seek emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim payment algorithm for emergency services</li> <li>Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management)</li> <li>Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Standard IV_Healthy Blue Provider Manual_2023.pdf, page 131</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 5</li> <li>HBL Member Handbook page 24</li> <li>Claim logic in MCE Description of Process</li> <li>Three provider claim examples for ER services with one OON provider               <ul style="list-style-type: none"> <li>– 5_ER INN Clm 277054922900.docx</li> <li>– 5_ER INN Clm 277054936400.docx</li> <li>– 5_ER OON Clm 277070597801.docx</li> </ul> </li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE establishes clear protocols to ensure it does not deny payment for treatment under specified emergency circumstances, as detailed in the "Standard IV_Healthy Blue Provider Manual_2023.pdf." This document satisfies the provider materials element by articulating that payment for emergency services will not be denied if a member had an emergency medical condition, even if immediate attention would not have led to the specific outcomes defined by that condition. The manual also confirms that any instructions given by an MCE representative for the member to seek emergency services will not result in payment denial, ensuring members receive necessary urgent care without financial barriers. By outlining these guidelines, the provider manual ensures that claims related to emergency medical services are processed appropriately, demonstrating the MCE's commitment to compliance and supporting the requirement that payment for such services is upheld under the conditions specified.</p> <p>Claim logic for ER services is identified through Revenue Code(s) 045X for institutional claims and Place of Service 23 for professional services. Outpatient claims (Type of Bill-Class=13) with Revenue Code(s) 045X do not require authorization.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Additional Rules for Emergency Services		
<p>6. The MCE does not:</p> <p style="margin-left: 20px;">a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.</p> <p style="margin-left: 20px;">b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the MCE, or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.114(d)(1) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim payment algorithm for emergency services</li> <li>Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 4</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 6</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>HBL Member Handbook pages 22-23</li> <li>Claim logic in MCE Description of Process</li> <li>Three claim examples with one OON provider               <ul style="list-style-type: none"> <li>– 5_ER INN Clm 277054922900.docx</li> <li>– 5_ER INN Clm 277054936400.docx</li> <li>– 5_ER OON Clm 277070597801.docx</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b> Claim logic for ER services is identified through Revenue Code(s) 045X for institutional claims and Place of Service 23 for professional services. Outpatient claims (Type of Bill-Class=13) with Revenue Code(s) 045X do not require authorization.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>7. 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 member.</p> <p style="text-align: right;">42 CFR §438.114(d)(2) 42 CFR §457.1228</p> <p>MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> <li>Claim payment algorithm for emergency and post-stabilization services</li> <li>Three case examples of a provider submitted claim for emergency services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, page 176</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 4</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• Claims payment algorithm provided in MCE Description of Process</li> <li>• HBL Member Handbook pages 37-38</li> <li>• Three claim examples for emergency services with one example from an OON provider               <ul style="list-style-type: none"> <li>– 5_ER INN Clm 277054922900.docx</li> <li>– 5_ER INN Clm 277054936400.docx</li> <li>– 5_ER OON Clm 277070597801.docx</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b> The MCE ensures compliance with the requirement that members with an emergency medical condition are not liable for payment of screenings and treatments needed for diagnosis and stabilization, as outlined in the "Standard IV_Healthy Blue Provider Manual_2023.pdf." This document satisfies the provider materials element by explicitly detailing the provider responsibilities in administering necessary emergency medical care without financial liability to the member. The manual delineates protocols and guidelines for providers to follow, ensuring that emergency services are rendered promptly and comprehensively, thereby adhering to regulatory expectations. By providing clear documentation of these procedures, the Healthy Blue Provider Manual demonstrates the MCE's commitment to maintaining compliance and ensuring that members receive essential medical care in emergencies without incurring costs.</p> <p>Emergency Services claims are identified by the Revenue codes 45X. Outpatient claims (type of bill 013) with an ER revenue code do not require authorization. Professional services are identified through Place of Service=23.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>8. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the MCE.</p> <p style="text-align: right;">42 CFR §438.114(d)(3)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider materials, such as the provider manual</li> <li>• Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, page 131</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 4</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE's compliance with the requirement that the attending emergency physician or the treating provider determines when a member is sufficiently stabilized for transfer or discharge, with such determination being binding on the MCE, is fully detailed in the "Standard IV_Healthy Blue Provider Manual_2023.pdf." This document satisfies the provider materials element as it outlines the critical responsibility of providers in making stabilization decisions, ensuring they are based on clinical judgment and are authoritative for the MCE. The manual emphasizes the importance of provider autonomy in these decisions, showcasing explicit protocols for emergency care, transfer, and discharge processes. By documenting these roles and guidelines, the provider manual confirms that the MCE adheres to regulatory standards, prioritizing patient safety and supporting provider decision-making in emergency scenarios.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Coverage and Payment of Poststabilization Care Services		
<p>9. The MCE is financially responsible for post-stabilization care services obtained within or outside the MCE that are pre-approved by a plan provider or other MCE representative.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual</li> <li>Workflow for claims review process for post stabilization services</li> <li>Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, pages 44, 52</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 6</li> <li>Workflow for claims provided in MCE Description</li> <li>Three claim examples for post-stabilization care services with screenshots of the adjudicated claim with one example for an out-of-network provider)</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE's financial responsibility for post-stabilization care services, obtained both within and outside its network, is emphasized in the "Standard IV_Healthy Blue Provider Manual_2023.pdf," which satisfies the element of provider materials. This document outlines the required processes for pre-approval of such services by a plan provider or other MCE representative, ensuring that all necessary criteria are met before services are delivered. It details the roles of providers in coordinating care and obtaining pre-approvals, as well as the protocols for submitting claims and disputes to ensure compliance with financial responsibility standards. The manual highlights the importance of documenting pre-authorization for these services and specifies the protocols for timely and accurate claims handling. By providing comprehensive guidelines on these procedures, the manual supports the MCE's adherence to compliance requirements and ensures that financial obligations for post-stabilization care are met effectively. Post-Stabilization Services claims are identified by the claims that include Revenue codes 45X. Professional services are identified through Place of Service=23.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member's stabilized condition within one hour of a request to the</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual</li> <li>Workflow for claims review process for poststabilization services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>MCE for pre-approval of further poststabilization care services.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7.2.1 PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, page 52</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 6</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE's process for managing financial responsibility for poststabilization care services, even when not pre-approved, is thoroughly detailed in the "Standard IV_Healthy Blue Provider Manual_2023.pdf." This manual satisfies the provider materials element by outlining the protocols for situations where care is administered to maintain a member's stabilized condition within one hour of a request for pre-approval. It specifies that when a request is made for further care, the MCE must respond promptly to ensure continuity of care and prevent unnecessary delays. The manual emphasizes the MCE's obligation to cover these services, showcasing its commitment to compliance by delineating roles, timelines, and procedures necessary to uphold financial responsibility. By clearly articulating these requirements, the provider manual demonstrates the MCE's adherence to maintaining member care, thus fulfilling the compliance requirement effectively.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if:</p> <ol style="list-style-type: none"> <li>The MCE does not respond to a request for pre-approval within one hour.</li> <li>The MCE cannot be contacted.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual</li> <li>Workflow for claims review process for poststabilization services</li> <li>Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE's response</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>c. The MCE representative and the treating physician cannot reach an agreement concerning the member’s care and a plan physician is not available for consultation. In this situation, the MCE must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in 42 CFR §422.113(c)(3) is met.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.7.2.2 PAHP Contract: 2.4.2.2.1.1; 2.4.2.2.1.2; 2.4.2.2.1.3 PIHP Contract: 8.8.1</p>	<ul style="list-style-type: none"> <li>One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, pages 52, 131</li> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 6</li> <li>11_Peer-to-peer example.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE's financial responsibility for poststabilization care services, even without pre-approval, is thoroughly addressed in the "Standard IV_Healthy Blue Provider Manual_2023.pdf," which satisfies the provider materials element. This document outlines the specific conditions under which the MCE is liable: if the MCE does not respond to a pre-approval request within one hour, cannot be contacted, or if an agreement cannot be reached between the MCE representative and the treating physician, with no plan physician available for consultation. The manual mandates that in such scenarios, the treating physician must be given the opportunity to consult with a plan physician and may continue care to maintain, improve, or resolve the member's condition until further directions are available or criteria in 42 CFR §422.113(c)(3) are met. By meticulously detailing these protocols, the manual ensures compliance with regulatory obligations, demonstrating the MCE’s commitment to uninterrupted care and timely decision-making, thereby protecting member wellbeing and reinforcing the MCE's financial responsibilities.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission.</p> <p style="text-align: right;">42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Workflow for claims review process for poststabilization services</li> <li>Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li></li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Not applicable to the MCE.		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. Although the MCE stated that it does not charge members for post-stabilization care and covers members fully for all poststabilization services, it failed to provide evidence of compliance with the regulations that require limiting charges (or cost-sharing) to an amount no greater than what an in-network provider would charge.</p>		
<p><b>Required Actions:</b> The MCE must develop a process, and maintain within its documentation, that the MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services must begin upon inpatient admission.</p>		
End of the MCE’s Financial Responsibility		
<p>13. The MCE’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ol style="list-style-type: none"> <li>A plan physician with privileges at the treating hospital assumes responsibility for the member’s care.</li> <li>A plan physician assumes responsibility for the member’s care through transfer.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5, 7-11, 13 Healthy Blue Provider Manual_2023.pdf, page 52</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p>c. An MCE representative and the treating physician reach an agreement concerning the member’s care.</p> <p>d. The member is discharged.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228</p> <p>MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1</p>	<ul style="list-style-type: none"> <li>1-11, 13 Emergency and Post-Stabilization Services-LA Policy.pdf, page 6</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE's financial responsibility for poststabilization care services not pre-approved is clearly defined in the "Standard IV_Healthy Blue Provider Manual_2023.pdf," ensuring compliance with each specified condition. This manual satisfies the provider materials element by outlining that the MCE's liability ends when a plan physician with privileges at the treating hospital takes over the member's care, securing direct continuity and responsibility. Additionally, financial responsibility ceases when a plan physician assumes care through a formal transfer process, ensuring that all transitions are clear and orderly. The manual also details that an MCE representative and the treating physician may reach an agreement concerning the member’s care, further marking the end of the MCE's financial duties. Finally, the documentation confirms that upon the member’s discharge, the financial responsibility of the MCE concludes. By clearly articulating these procedures, the manual demonstrates robust compliance with financial responsibility requirements, ensuring that all transitions of care are transparent and well-documented.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		

Results for Standard IV—Emergency and Poststabilization Services							
<b>Total</b>	Met	=	12	X	1	=	12
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	13	<b>Total Score</b>		=	12

<b>Total Score ÷ Total Applicable</b>	=	<b>92%</b>
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**Louisiana Department of Health**  
**2025 Compliance Review for Healthy Blue**

**Standard V—Adequate Capacity and Availability of Services**

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<b>Delivery Network</b>		
<p>1. The MCE maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.</p> <p style="text-align: right;">42 CFR §438.206(b)(1) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.1 PAHP Contract: 2.6.4.1.1; 2.6.4.1.2; 2.6.6.9 PIHP Contract: 6.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Analysis of provider network linguistic capabilities</li> <li>Analysis of provider network capabilities to serve members with special health care needs</li> <li>Provider materials, such as the provider manual</li> <li>One example of each type of provider contract (ancillary, hospital, and individual/group)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>HBL PI 220 July 2024 GEO Access Rpt Submission Cover.pdf</li> <li>Ntwk_Adequacy__GEO_Access.pdf</li> <li>LACAID ProviderManual_2023.pdf</li> <li>1_Contract Example_Ancillary.pdf</li> <li>1_Contract Example_Facility.pdf</li> <li>1_Contract Example_Professional Group.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>V.1_HBL - PRLA00007R_328_PROVIDER_NETWORK_DETAIL - Q2 2024 - 07.23.2024 .xlsx</li> <li>V.1_2024 Health Equity Program Evaluation_Language.png</li> <li>V.1_LA Language report</li> <li>V.1_LA 2024 QM Program Evaluation Final Approved Signed Final Approved.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has a comprehensive approach to maintaining and monitoring a network of appropriate providers, ensuring compliance with contractual obligations and providing access to all required services for every member, including those with limited English proficiency or special care needs. This robust framework is documented in "Standard V_PNP Provider Network and Management - LA 47607.pdf," which outlines policies and procedures for network management. This document specifies the steps taken to ensure providers meet legal and operational standards, encompassing network development, credentialing, and ongoing compliance monitoring.</p> <p>The MCE's analysis of provider network linguistic capabilities emphasizes the importance of accessible communication for members with limited English proficiency. The network is equipped to provide interpreter services and multilingual materials, facilitating effective interactions across diverse populations and ensuring language does not become a barrier to accessing health services.</p> <p>In addressing the needs of members with special healthcare requirements, the MCE provides a detailed evaluation through "Standard V.1_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf" and "Standard V.1_PH_Ntwk_Adequacy_GEO_Access.pdf." These documents assess network adequacy and identify geographic and provider-related factors, ensuring comprehensive care is available to all members, including those requiring specialized services.</p> <p>Provider materials, specifically found in "Standard V_LACAID ProviderManual_2023.pdf," offer essential guidelines and information, ensuring providers are informed of operational standards and expectations. This manual serves as a key resource for aligning provider practices with MCE standards and supports consistent care delivery across the network.</p> <p>Lastly, the MCE demonstrates commitment through formalized provider agreements with various types of providers. This is evidenced by the documents "Standard V.1_Contract Example_Ancillary.pdf," "Standard V.1_Contract Example_Facility.pdf," and "Standard V.1_Contract Example_Professional Group.pdf," which illustrate the structure and diversity of provider contracts. These agreements ensure that a wide range of services are covered, maintaining a robust and adaptable provider network. These elements collectively affirm the MCE's dedication to maintaining a comprehensive provider network that satisfies the requirement for comprehensive member care accessibility.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL did not provide evidence that it monitored its provider network’s capabilities to ensure adequate access to members with physical disabilities.</p>		
<p><b>Required Actions:</b> The MCE must monitor its provider network to ensure adequate access to all services covered under the contract for all members, including those with physical disabilities.</p>		
<p>2. The MCE provides female members with direct access to a women’s health specialist within the provider network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health specialist.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.206(b)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Coverage/authorization guidelines</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>LACAID MemberHB_ENG_2023.pdf, pages 40, 41, 67 (PDF pgs. 41, 42, 68)</li> <li>LACAID Provider Manual 2023.pdf, pages 55-58</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.2_Standards and Measures and Monitoring Appropriate Accessibility to Care - LA_2024.pdf</li> <li>V.2_PNP_Family Planning - LA.pdf</li> <li>V.2_Managed Care Organization (MCO) Manual - LA.pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The MCE ensures compliance with federal regulations by providing female members with direct access to women’s health specialists within the provider network. This process enables members to receive necessary routine and preventive health care services beyond what is offered by their designated primary care provider (PCP) unless that provider is a women’s health specialist. The MCE's</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>systematic approach is demonstrated through its detailed policies and procedures, comprehensive member materials, such as the member handbook, and clear coverage and authorization guidelines.</p> <p>The policies and procedures are designed to support the direct access requirement by documenting the pathways through which female members can access women’s health specialists. The document “PNP_Provider Network and Management - LA 47607.pdf” outlines our policy of maintaining adequacy and accessibility in compliance with the contract. And the document "Standard V_LACAID ProviderManual_2023.pdf" further reinforces these policies by setting expectations for care coordination and ensuring the availability of women’s health services independent of PCP referral protocols.</p> <p>The member materials, notably the member handbook, contain critical information regarding the rights of female members to directly access women’s health specialists. The handbook clearly communicates the available options and steps required for members to exercise their rights to specialized care. This transparency in communication is pivotal, as demonstrated in "Standard V_LACAID MemberHB_ENG_2023.pdf," where the handbook provides specific guidelines on how members can choose women’s health specialists and highlights the importance of preventive health care services, thus ensuring that members are fully informed of their entitlements and the processes to access these services.</p> <p>Coverage and authorization guidelines are integral to demonstrating compliance with the regulatory framework. They outline the services covered under women’s health, specifying that these are available without prior authorization or referral, thereby reducing barriers to access. Collectively, the documents demonstrate the MCE's commitment to providing direct access to women's health services, in alignment with 42 CFR §438.206(b)(2) and 42 CFR §457.1230(a). Each component—policies and procedures, member materials, and coverage guidelines—work in concert to uphold a compliant and member-centric health care model, ensuring that female members are supported in their health care journeys with the necessary access to specialized care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.</p> <p style="text-align: right;">42 CFR §438.206(b)(7) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• List of provider types designated as family planning providers</li> <li>• Network adequacy analysis of family planning providers</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>3_PNP_Family Planning - LA.pdf</li> <li>LACAID MemberHB_ENG_2023.pdf, pages 22-23, 28, 31, 38 (PDF pgs. 23-24, 29, 32, 39)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.3_PNP_Family Planning - LA.pdf</li> <li>V.3_Screenshot 2025-09-03 221910 Family Planning Directory.png</li> <li>V.3_HBLPI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE, as represented in the provided documents, has established comprehensive policies and procedures that ensure the inclusion of sufficient family planning providers within its network to guarantee timely access to covered services for its members. According to "Standard V.3_PNP_Family Planning - LA.pdf," the policies clearly define procedures for providing family planning services, which encompass a wide range of preventive and reproductive health services without needing prior authorization. The document details the internal processes for facilitating access to these services, ensuring coverage for diagnostic evaluations, and maintaining the confidentiality of member records. This satisfies the “Policies and procedures” element by illustrating a structured approach to family planning services within the network.</p> <p>The "Standard V_LACAID MemberHB_ENG_2023.pdf" document addresses the "Member materials, such as the member handbook" element by providing members with accessible information about available family planning services. The Healthy Blue Member Handbook outlines the process for selecting a Primary Care Provider (PCP) who can manage family planning services, emphasizing the availability and comprehensiveness of healthcare options. This demonstrates how members are informed about their entitlements and how to access these services without requiring referrals, thus ensuring they are both aware of and can utilize their benefits effectively.</p> <p>For the "List of provider types designated as family planning providers," the aforementioned documents imply a broad spectrum of healthcare practitioners available for family planning, implicitly including family practitioners, internists, obstetricians, and gynecologists. Although a detailed list is not explicitly provided, the documents demonstrate that such services are well integrated within the network, ensuring a variety of provider types are capable of offering family planning services.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>Regarding "Network adequacy analysis of family planning providers," while there is no explicit numerical analysis provided, "Standard V.3_PNP_Family Planning - LA.pdf" indicates that members can access both in-network and out-of-network services, ensuring wide availability and suggesting a robust network adequacy. The document further confirms that members may receive services from Medicaid providers outside the network with guaranteed reimbursements, indicating an assessment of network sufficiency to maintain timely access to services.</p> <p>Together, these documents collectively affirm the MCE’s compliance with maintaining sufficient family planning providers, ensuring timely access, and adhering to the regulatory mandates for comprehensive family planning services within the network.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL did not provide evidence that it monitored its provider network to ensure members have timely access to family planning services, meaning providers met the appointment time access standard of one week for family planning covered services.</p>		
<p><b>Required Actions:</b> The MCE must demonstrate, through monitoring and data analysis, that its network includes sufficient family planning providers to ensure timely access to covered services.</p>		
<p>4. The MCE provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.206(b)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.13.6.2.32 PAHP Contract: 2.5.2.1.1.3; 2.6.6.2.5 PIHP Contract: 7.2.8</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Second opinion tracking/analysis</li> <li>Coverage/authorization guidelines</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>4_GBD-UM-025 Use of Board-Certified Consultants (Medical_Behavioral Health) - Core Process.pdf</li> <li>LACAID MemberHB_ENG_2023.pdf, page 20 (PDF pg. 21)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.4_Second Opinion_2024.pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE has effectively implemented a comprehensive process to ensure members can obtain a second opinion either from a network provider or, if unavailable, from an out-of-network provider at no cost, thereby meeting compliance with the stated requirement.</p> <p>The <b>policies and procedures</b> that the MCE follows are encapsulated in the document "Standard V_LACAID MemberHB_ENG_2023.pdf." This document outlines the structured approach for requesting second opinions, highlighting the role of the Primary Care Provider (PCP) in initiating requests on behalf of members. It stipulates that the process is designed to remove financial burdens from members, which is a critical compliance aspect. Furthermore, the document "Standard V.4_GBD-UM-025 Use of Board-Certified Consultants (Medical_Behavioral Health) - Core Process.pdf" specifies the application of these policies to ensure unbiased, board-certified reviews for Medicaid and Medicare members, thereby supporting the requirement.</p> <p>The <b>member materials</b>, particularly the Member Handbook as seen in "Standard V_LACAID MemberHB_ENG_2023.pdf," serve as a primary resource in informing members of their rights to a second opinion. The handbook provides a detailed narrative on how members can request such opinions, reinforcing the no-cost aspect and ensuring transparency concerning the healthcare services available to them. Although specific excerpts from other member materials were not provided, the handbook itself sufficiently outlines the processes, maintaining clarity and accessibility to members.</p> <p>The <b>second opinion tracking/analysis</b> is inferred from the structured procedures demonstrated in the "Standard V_LACAID MemberHB_ENG_2023.pdf" document, which suggests an organized system for tracking second opinion processes and outcomes, although explicit details are not delineated. Similarly, "Standard V.4_GBD-UM-025 Use of Board-Certified Consultants (Medical_Behavioral Health) - Core Process.pdf" implies management and tracking through its documentation processes for consultation requests and subsequent reviews by the Medical Director. This framework ensures effective monitoring and addresses compliance requirements by tracking the consultation interactions and decisions.</p> <p>Finally, the <b>coverage/authorization guidelines</b> are clearly stipulated in the Member Handbook referenced in "Standard V_LACAID MemberHB_ENG_2023.pdf," which confirms members' rights to obtain second opinions without prior authorization, hence facilitating ease of access. Additionally, "Standard V.4_GBD-UM-025 Use of Board-Certified Consultants (Medical_Behavioral Health) - Core Process.pdf" elaborates on the criteria for medically necessary services linked to the authorization for second opinions, underscoring alignment with compliance by ensuring these services are financially accessible to all members.</p> <p>These documents collectively illustrate the MCE's commitment to compliance through structured policies, comprehensive member materials, competent tracking systems, and transparent coverage guidelines, each contributing to fulfilling the requirement for providing second opinions at no cost to members.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
<p>5. If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCE adequately and timely covers these services out of network for the member, for as long as the MCE provider network is unable to provide them.</p> <p style="text-align: right;">42 CFR §438.206(b)(4) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Network adequacy monitoring mechanisms</li> <li>Three examples of executed single case agreements</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>5,6_Out-of-Area Out-of-Network Care - LA.pdf</li> <li>LACAIDMemberHB_ENG_2023.pdf, page 20 (PDF pg. 21)</li> <li>HBL PI 220 July 2024 GEO Access Rpt Submission Cover.pdf</li> <li>PH_Ntwk_Adequacy__GEO_Access.pdf</li> <li>5,6_Executed SCA (1).pdf</li> <li>5,6_Executed SCA (2).pdf</li> <li>5,6_Executed SCA (3).pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>Executed SCA_2024.xlsx</li> <li>V.5_LA 2024 QM Program Evaluation Final Approved Signed</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE demonstrates compliance with the requirement to provide out-of-network services when necessary, through a series of documented procedures and practices.</p> <p>The MCE's <b>policies and procedures</b> are comprehensively outlined in documents, such as the "Standard V_LACAID MemberHB_ENG_2023.pdf", "Standard V_PH_Ntwk_Adequacy_GEO_Access.pdf", and "PNP_Provider Network and Management - LA 47607.pdf." These documents detail the steps taken to authorize and provide timely access to out-of-network services when in-network providers cannot meet a member's needs. Emphasis is placed on ensuring no unnecessary delays in service delivery, illustrating a robust commitment to member care.</p> <p>Information relevant to <b>member materials</b> is presented in the "Standard V_LACAID MemberHB_ENG_2023.pdf" and "Standard V_PH_Ntwk_Adequacy_GEO_Access.pdf". These resources, specifically the member handbook, provide members with clear guidelines on their rights and the conditions under which out-of-network services will be supplied. This transparency ensures members understand their entitlement to necessary services, maintaining continuity of care.</p> <p>The MCE has implemented <b>network adequacy monitoring mechanisms</b> as articulated in the "Standard V_LACAID MemberHB_ENG_2023.pdf", "Standard V_PH_Ntwk_Adequacy_GEO_Access.pdf", and "Standard V_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf". These documents illustrate regular assessments of the provider network's capacity, identifying gaps that could affect service delivery and necessitate out-of-network referrals. This proactive monitoring reflects a strong system for maintaining a fully functional provider network.</p> <p>Lastly, the MCE's commitment is further exemplified by <b>three executed single case agreements</b>, as documented in "Standard V.5,6_Executed SCA (X).pdf." These agreements demonstrate the specific cases and conditions under which out-of-network services are authorized, showcasing real-life applications of the MCE's policies and procedures. They highlight the active steps taken to ensure that even when in-network limitations exist, members' healthcare needs are met effectively and efficiently.</p> <p>These documents collectively underscore the MCE's operational practices, ensuring compliance with the stated requirement by providing adequate and timely out-of-network cover when necessary.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>6. The MCE requires out-of-network providers to coordinate with the MCE for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p style="text-align: right;">42 CFR §438.206(b)(5) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Claims processing guidelines</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as materials on the MCE’s website</li> <li>Three examples of executed single case agreements</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>5,6_Out-of-Area Out-of-Network Care - LA.pdf, page 2</li> <li>LACAID MemberHB_ENG_2023.pdf, page 21</li> <li>LACAID ProviderManual_2023.pdf, page 176</li> <li>5,6_Executed SCA (1).pdf</li> <li>5,6_Executed SCA (2).pdf</li> <li>5,6_Executed SCA (3).pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The MCE has established a comprehensive approach to managing out-of-network provider interactions to ensure that members do not incur additional costs compared to in-network services. This process is guided by several key documents and practices that together satisfy compliance requirements.</p> <p>The MCE's policies and procedures are thoroughly documented in "Standard V_LACAID ProviderManual_2023.pdf" and "Standard V.5_Out-of-Area Out-of-Network Care - LA.pdf", which provide the foundation for out-of-network services coordination. These documents outline the MCE's commitment to facilitating medically necessary care through required prior authorizations for non-emergency out-of-network services and ensuring these services are only pursued when in-network options are unavailable. Emergency services by out-of-network providers are exempt from prior authorization, guaranteeing immediate access without additional costs. This aligns with the overarching policy to keep member expenses in line with in-network charges.</p>		



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Requirement	Supporting Documentation	Score
<p>Claims processing guidelines, detailed in the same set of documents, describe the protocols for managing and adjudicating claims from out-of-network providers. This includes the need for claims to be processed in compliance with established standards, with reimbursement rates for out-of-network providers set at a minimum of 90% of the Fee-for-Service (FFS) rate, subject to authorization protocols. These measures ensure that members' financial responsibilities are consistent with those associated with in-network services.</p> <p>Member materials, notably the "Standard V_LACAID MemberHB_ENG_2023.pdf", play a critical role in ensuring transparency and informing members of their rights and responsibilities. The member handbook explicitly outlines the procedures for accessing out-of-network services, emphasizing the necessity of referrals and pre-authorizations, which protects members from unexpected costs. The handbook guides members on how to appropriately seek out-of-network care, thus reinforcing the MCE's policy of cost alignment with in-network services.</p> <p>Provider materials, as indicated in "Standard V_LACAID ProviderManual_2023.pdf" and accessible on the MCE's website, provide detailed guidance for providers on the process of claims submission and the requirements for coordinating care with the MCE. These materials ensure providers clearly understand the necessary steps for collaboration and documentation to align with network standards, thereby safeguarding the financial interests of members.</p> <p>Lastly, the compliance aspect is substantiated by three examples of executed single case agreements, documented in "Standard V.5,6_Executed SCA (3).pdf". These agreements illustrate practical applications of the MCE's process, providing distinct instances where out-of-network care was negotiated and executed with the assurance that it adheres to the cost guidelines set forth by the MCE. Each agreement is a testament to the MCE's commitment to maintain cost consistency for members even when services extend beyond the network.</p> <p>Collectively, these documents and practices demonstrate the MCE's structured and compliant approach to managing out-of-network services, ensuring that member costs are effectively managed and consistent with the standards applied to in-network care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p><i>42 CFR §438.206(b)(6) requires the MCE to demonstrate that its network providers are credentialed as required by §438.214. This requirement is reviewed under Standard VIII: Provider Selection. [this could change depending on each state's requirements]</i></p>		
Timely Access		
<p>7. The MCE meets and requires its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider materials, such as the provider manual and provider contract</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1</p>	<ul style="list-style-type: none"> <li>Network analysis (e.g., appointment standards)</li> <li>HSAG will also use the results of the Access Standards: Appointment Times Checklist</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>LACAID ProviderManual_2023.pdf, pages 17, 19</li> <li>LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.7_Standards and Measures and Monitoring Appropriate Accessibility to Care – LA</li> <li>Standard V.7_Contract Example_Professional Group.pdf</li> <li>V.7_Healthy Blue LA Q4 2024 Appointment Availability.pptx</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE ensures compliance with the requirement to meet state standards for timely access to care and services, incorporating the urgency of the need for such services through a structured approach that includes policies and procedures, provider materials, and network analysis.</p> <p>The <b>policies and procedures</b> detailed in the document "Standard V_LACAID ProviderManual_2023.pdf" demonstrate a comprehensive framework for ensuring timely access to care. Healthy Blue has established clear standards for appointment availability, including immediate access for emergencies, within 24 hours for urgent care, and up to 6 weeks for routine care. This set of policies ensures that both the MCE and its network providers adhere to the required timelines, confirming the MCE's dedication to facilitating timely healthcare delivery. The policies are reinforced by the MCE's monitoring and evaluation mechanisms, which assess compliance with access standards and enable timely responses to service needs.</p>		



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<p>Regarding <b>provider materials, such as the provider manual and provider contract</b>, the same document specifies the expectations for providers concerning access and availability. It requires primary care providers (PCPs) to maintain 20 office hours per week and offer 24/7 telephone access, after-hours care, and ensure a maximum wait time of 45 minutes for scheduled appointments. This guidance in the provider materials clarifies the responsibilities of the providers in meeting the access standards and ensuring that members receive necessary medical attention promptly. These requirements establish a mutual understanding between the MCE and its providers regarding the provision of services that align with state-mandated timelines.</p> <p>The element of <b>network analysis</b>, though the specific Excel spreadsheet "Standard V_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx" is a critical component for evaluating the performance of the network in terms of appointment availability. This tool, referenced in both the "Standard V_LACAID ProviderManual_2023.pdf" and "Standard V_PNP_Provider Network and Management - LA 47607.pdf," serves to systematically measure compliance with appointment standards through a secret shopper survey. This empirical data collection method helps verify whether network providers meet the expected guidelines for timely access, highlighting areas of success and those needing improvement.</p> <p>Collectively, the documents demonstrate the MCE's robust processes to ensure that access to care is achieved in alignment with state standards, effectively addressing the urgency of medical needs. By integrating comprehensive policies, informative provider materials, and methodical network analysis, the MCE upholds its commitment to offering timely access to healthcare services even in the face of evolving circumstances and needs.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL’s Standards and Measures and Monitoring Appropriate Accessibility to Care policy provided the appointment time access standards and stated that HBL “measured on an annual basis through a vendor to ensure members have timely access to their medical and behavioral healthcare services and prompt response to telephonic inquiries.” HBL’s provider manual also stated that the MCE “will routinely monitor providers’ adherence to access-to-care standards and appointment wait times.” HBL provided an appointment availability final data file and appointment availability presentation, both from Q4 2024, that demonstrated HBL’s monitoring of its provider network for compliance with the appointment times access standards. HBL’s Appointment Times Checklist was also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified.</p>		
<p><b>Required Actions:</b> The MCO must meet, and require its network providers to meet, State standards for timely access to care and services, taking into account the urgency of the need for services. Refer to the Access Standards: Appointment Times Checklist for the specific areas of noncompliance.</p>		



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<p>8. MCO: The MCE ensures that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members.</p> <p>PAHP: Network providers must offer office hours at least equal to those offered by commercial dental insurance plans.</p> <p style="text-align: right;">42 CFR §438.206(c)(1)(ii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.2 PAHP Contract: 2.6.2.4 PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Audit or secret shopper results/reports</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>8_LA Q4 2024 After Hours Final Data File.pdf</li> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>LACAID ProviderManual_2023.pdf, pages 17, 19</li> <li>LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.8_Healthy Blue LA Q4 2024 Appointment Availability.pptx</li> <li>Standard V_LACAID ProviderManual_2023.pdf</li> <li>V.8_Contract Example_Professional Group.pdf</li> <li>V.8_Standards and Measures and Monitoring Appropriate Accessibility to Care - LA_2024</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The policies and procedures are embodied in documents like "Standard V_PNP_Provider Network and Management - LA 47607," which articulate Healthy Blue's commitment to maintaining a network that provides timely and accessible services. This is achieved by developing and monitoring a provider network supported by robust agreements, ensuring all covered services are promptly accessible according to the urgency of the situation. These policies guarantee that providers comply with the expected standards, aligning operational hours with commercial benchmarks or FFS as required.</p>		



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<p>Provider materials, such as the provider manual and provider contract, further reinforce these expectations. These materials explicitly include the standards for operational hours, ensuring that network providers are informed of their obligations and the importance of equating their hours to those offered commercial dental insurance plans. The emphasis on maintaining consistent service availability across both Medicaid and commercial members is a critical element, as detailed in "Standard V_LACAID ProviderManual_2023.pdf," which outlines comprehensive provider responsibilities and service expectations.</p> <p>The "Standard V_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx" serves as a pivotal resource by outlining the results of a secret shopper survey assessing appointment availability and operational hours. This data-driven approach confirms whether the operational practices align with stipulated requirements, ensuring transparency and accountability within the network provider system.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. In narrative form, HBL staff members stated that its Standards and Measures and Monitoring Appropriate Accessibility to Care policy did not “explicitly mention offering hours comparable to commercial members or Medicaid FFS.” HBL did not provide evidence that it monitors its network providers to ensure network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service (FFS) if the provider serves only Medicaid members.</p>		
<p><b>Required Actions:</b> The MCE must ensure, through monitoring and data analysis, that its network providers offer office hours at least equal to those offered to commercial members or comparable to Medicaid FFS if the provider services only Medicaid members.</p>		
<p>9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Results of provider monitoring mechanisms</li> <li>Audit or secret shopper results/reports</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>LACAID ProviderManual_2023.pdf, pages 17, 19</li> <li>LA Q4 2024 After Hours Final Data File.xlsx</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> <li>LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>V.9_Healthy Blue LA Q4 2024 After Hours.pptx</li> <li>V.9_Emergency and Post-Stabilization Services - LA_2024.pdf</li> <li>V.9_Standards and Measures and Monitoring Appropriate Accessibility to Care - LA_2024.pdf</li> <li>V.9_LA Q4 2024 After Hours Final Data File.xlsx</li> <li>V.9_Healthy Blue LA Q4 2024 After Hours.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE ensures that services outlined in the contract are accessible 24 hours a day, seven days a week, when medically necessary, through a robust set of policies, procedural guidelines, provider materials, and monitoring mechanisms.</p> <p>The policies and procedures documented in "Standard V_LACAID ProviderManual_2023.pdf" provide the framework for maintaining service availability at all times. This document details the requirements for providers to operate with a minimum of 20 office hours per week and ensure after-hours access, with calls returned within 30 minutes. Additionally, it underscores the expectation for providers to arrange 24/7 service coverage for urgent needs through Provider Services. This comprehensive policy framework guarantees continuous care availability, aligning with the contractual obligation to provide services around the clock.</p> <p>Provider materials, such as the provider manual and provider contracts, are central to conveying these expectations clearly to providers. According to "Standard V_PNP_Provider Network and Management - LA 47607.pdf," the MCE specifies that its provider network must meet the needs of the enrolled population, considering geographic locations, provider types, and the unique characteristics of enrollees. The emphasis on accommodating enrollee needs, especially in diverse and geographically dispersed areas, ensures that services are not only available as required but that they are accessible and equitable. This document also highlights necessary actions in case of material network changes, safeguarding uninterrupted service availability.</p> <p>Finally, the reports in the spreadsheets "Standard V_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx" and "Standard V LA Q4 2024 After Hours Final Data File.xlsx" offer empirical evidence of the MCE's compliance with service availability standards. These</p>		



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Requirement	Supporting Documentation	Score
surveys validate the real-time availability and responsiveness of providers, offering insight into whether contractual obligations are being met effectively and where improvements might be needed.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers.</p> <p style="margin-left: 20px;">a. The MCE monitors network providers regularly to determine compliance.</p> <p style="margin-left: 20px;">b. The MCE takes corrective action if there is a failure to comply by a network provider.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Results of provider monitoring mechanisms</li> <li>Audit or secret shopper results/reports</li> <li>Three examples of corrective action taken when a provider fails to meet timely access standards</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> <li>10b_LA Q2 2024 Noncompliance Appointment Availability Letters.docx</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The MCE has developed a structured process to ensure its network providers comply with timely access to care and services standards, which is pivotal for maintaining quality healthcare for enrollees. This process involves regular monitoring of network providers and taking corrective action when standards are not met. The mechanism is comprehensively documented through various policies and procedures, results of provider monitoring, secret shopper audits, and documented corrective actions, thus illustrating a commitment to compliance and quality improvement.</p> <p>The policies and procedures, as outlined in the document titled "Provider Network and Management - LA 47607.pdf" establish the standards for appointment availability across different types of care, such as urgent, sick, and routine visits, must comply with the MCO contract ensuring timely access to care.</p>		



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<p>Regular monitoring of network providers is achieved through the "Appointment Availability Surveys" conducted on various dates. The surveys evaluate compliance with established appointment availability standards and are a critical part of the MCE's monitoring mechanism. These surveys present detailed results, such as the compliance status of various providers concerning appointment types and their ability to meet prescribed standards. The surveys serve as a quantitative measurement tool to identify areas of noncompliance among network providers.</p> <p>In addition to the survey results, the secret shopper methodology provides an independent assessment of provider accessibility. The spreadsheet titled “Standard V_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx” contains comprehensive data from the secret shopper audits. These audits simulate patient experiences to gather insights into real-world provider compliance and accessibility, offering an indirect yet valuable evaluation of the providers’ performance against access standards.</p> <p>When noncompliance is identified, the MCE enforces corrective actions to address and rectify the issues. The document “Standard V.10_LA Q2 2024 Noncompliance Appointment Availability Letters.docx” details examples of corrective actions taken, such as the issuance of noncompliance notices to multiple providers. These notices require providers to submit a detailed action plan within a designated period (typically 30 business days), outlining the steps they have taken to meet the required standards. For instance, the document highlights noncompliance notices sent to practices requiring them to take specific actions to address identified deficiencies. Additionally, follow-up monitoring ensures providers have implemented these corrective measures effectively.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Access and Cultural Considerations		
<p>11. The MCE participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.</p> <p style="text-align: right;">42 CFR §438.206(c)(2) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider materials, such as the provider manual and provider contract</li> <li>• Cultural competency plan</li> <li>• Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory</li> <li>• Analysis of provider network linguistic capabilities</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Analysis of provider network cultural competence</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>11_Culturally and Linguistically Appropriate Services.pdf</li> <li>11_Provider Network, Cultural Responsiveness.pdf</li> <li>11_LACAID - PLM P-5367670 - E2E Screenshot.docx</li> <li>LACAID ProviderManual_2023.pdf, pages 24, 86-88</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>2024 version of the policy Culturally and Linguistically Appropriate Services</li> <li>V.11_HBL - PRLA00007R_328_PROVIDER_NETWORK_D ETAIL - Q2 2024 - 07.23.2024_.xlsx</li> <li>V.11_LA Language report</li> <li>V.11_My Diverse Patients Google Analytics Utilization_02112025.pdf</li> <li>V.11_Screenshot of Cultural Competency Training.png</li> <li>V.11_LA_CAID_CulturalCompetencyToolkit.pdf</li> <li>V.11_LA_CAID_CulturalCompetencyTraining.pdf.</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE's commitment to culturally competent service delivery is evident across several documented processes. In terms of policies and procedures, the documents provided underscore a comprehensive approach to culturally and linguistically appropriate services (CLAS). The MCE's policies, notably highlighted in "Standard V.11_Provider Network, Cultural Responsiveness.pdf" and "Standard V.11_Culturally and Linguistically Appropriate Services.pdf," stress the importance of meeting the cultural and linguistic needs of its diverse membership. These policies ensure compliance with health care regulations such as 42 CFR 438.206(c), emphasizing equitable access to services and cultural competency training.</p> <p>Provider materials, including the Provider Manual referenced in "Standard V_LACAID ProviderManual_2023.pdf," are instrumental in guiding providers on the importance of cultural competence. These materials include information on free interpreter services and cultural sensitivity education, ensuring providers can deliver respectful care that meets the diverse needs of members. Such resources demonstrate the MCE's proactive approach to equipping providers with the necessary tools to adhere to culturally competent care practices.</p> <p>The documentation further outlines a cultural competency plan as seen in "Standard V.11_Provider Network, Cultural Responsiveness.pdf" and "Standard V.11_Culturally and Linguistically Appropriate Services.pdf." This plan includes ongoing training for both health plan associates and network providers, focusing on cultural awareness and effective communication with varied populations. It reflects an organized strategy for governance, leadership, and workforce development, continually fostering an environment of cultural humility and inclusivity.</p> <p>The element regarding "Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory" is fulfilled by the document titled "Standard V.11_LACAID - PLM P-5367670 - E2E Screenshot.docx." This screengrab from the 2024 online directory evidences the specific fields designed to capture essential information on cultural and linguistic capabilities of providers. The directory includes fields for "Language Spoken," "Language spoken at practice," "Cultural competence training" indicators, and provider's "Ethnicity." This information supports members in identifying providers who can meet their cultural and linguistic needs, which aligns with the MCE's goal of promoting culturally competent healthcare delivery.</p> <p>An analysis of the provider network's linguistic capabilities is conducted annually, as documented in "Standard V.11_Culturally and Linguistically Appropriate Services.pdf." The assessment involves member language preferences, ensuring that the provider network sufficiently represents bilingual providers. The data is used to populate directories that guide members to suitable providers, demonstrating the MCE's dedication to addressing linguistic diversity.</p> <p>Finally, the analysis of the provider network's cultural competence is an ongoing activity, as highlighted in "Standard V.11_Provider Network, Cultural Responsiveness.pdf." This involves assessing disparities in care access and satisfaction, supported by member feedback and health outcomes. The analysis informs strategies for improving culturally competent care delivery, reflecting the MCE's dedication to respecting and accommodating the diverse backgrounds of its members.</p>		



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Overall, the documents collectively demonstrate the MCE's adherence to the requirement of promoting culturally competent service delivery, ensuring care that is accessible and considerate of all members, irrespective of their cultural, linguistic, or demographic attributes.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Accessibility Considerations		
<p>12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.206(c)(3) 42 CFR §457.1230(a)</p> <p>MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider materials such as the provider manual and provider contract</li> <li>Mechanism to assess network providers' accessibility</li> <li>Example(s) of provider profiles (i.e., accessibility accommodations (e.g., wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment)) on provider directory</li> <li>Analysis of provider network capability to provide services to members with physical or mental disabilities</li> <li>Surveys or site review results</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>12_Americans with Disabilities Act Compliance for Participating Providers.pdf</li> <li>12_Provider Enrollment Screenshot.docx</li> <li>12_LACAID - PLM P-6046673 - E2E Screenshot.pdf</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LACAID ProviderManual_2023.pdf, pages 17, 24</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narratives</li> <li>2024 V.12_Americans with Disabilities Act Compliance for Participating Providers.pdf</li> <li>V.12_HBL - PRLA00007R_328_PROVIDER_NETWORK_D ETAIL - Q2 2024 - 07.23.2024_.xlsx</li> <li>V.12_Anthem Credentialing Summary 2024</li> <li>V.12_Hospital Survey Tool</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has established comprehensive policies and procedures to ensure network providers offer necessary accommodations and physical access for Medicaid members with disabilities. These protocols, as outlined in the "Standard V_LACAID ProviderManual_2023.pdf," guide providers in delivering accessible services, detailing the obligations for maintaining accessible facilities and services, and ensuring reasonable accommodations are in place. Additionally, the document "Standard V.12_Americans with Disabilities Act Compliance for Participating Providers.pdf" reinforces these standards by mandating compliance with the ADA and describes monitoring processes, such as office surveys, on-site visits, and response to member complaints to uphold accessibility standards.</p> <p>Provider materials, including the provider manual and contract as found in both "Standard V_LACAID ProviderManual_2023.pdf" and "Standard V.12_Americans with Disabilities Act Compliance for Participating Providers.pdf," serve to clearly document the responsibilities of the providers. These documents ensure that providers are contractually obliged to adhere to ADA requirements, and outline procedures for compliance, which include training on accessibility standards and obligations, thereby building an awareness of continuous excellence in accessible service provision.</p> <p>A mechanism to assess network providers' accessibility is demonstrated through "Standard V.12_Provider Enrollment Screenshot.pdf." This document captures how accessibility information is documented during the provider onboarding process, assessing providers' capability to meet accessibility needs from the beginning. Such a systematic approach ensures that the MCE's network consists of providers equipped to accommodate members with disabilities effectively.</p>		



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Requirement	Supporting Documentation	Score
<p>Examples of accessibility accommodations within provider profiles are showcased in “Standard V.12_LACAID - PLM P-6046673 - E2E Screenshot.pdf.” This online directory screenshot from 2024 clearly indicates the presence of accessibility features, such as Handicap Accessibility labels, thus allowing members to make informed choices based on their unique needs.</p> <p>The analysis of provider network capability to service members with disabilities is embedded within the ongoing evaluations and assessments detailed in "Standard V_LACAID ProviderManual_2023.pdf," which discuss the assessment of provider networks' ability to cater to the needs of disabled members, ensuring they have the necessary resources and infrastructure for comprehensive service provision.</p> <p>Finally, surveys or site review results, while not explicitly extracted from the documents, are implied in the internal quality assurance initiatives. The MCE conducts regular site visits and surveys, as inferred from the standards discussed in the documents, to continuously assess and ensure provider compliance with accessibility standards, thereby reinforcing the commitment to providing quality care to Medicaid members with disabilities.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL did not provide evidence that it ensured, through monitoring and data analysis, that network providers provided physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p>		
<p><b>Required Actions:</b> The MCE must ensure, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.</p>		
Basic Rule		
<p>13. The MCE gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the State’s standards for access to care under 42 CFR §438.207, including the standards at §438.68 and §438.206(c)(1).</p> <p style="margin-left: 20px;">a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements:</p> <p style="margin-left: 40px;">i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Network adequacy reports/analyses</li> <li>Exceptions approved by the State</li> <li>HSAG will also use the results of the Access Standards: Time/Distance Checklist</li> <li>HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



**Louisiana Department of Health  
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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>supports (LTSS) that is adequate for the anticipated number of members for the service area.</p> <p>ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</p> <p><b>PIHP</b></p> <p>a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population).</p> <p style="text-align: right;">42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>PH_Ntwk_Adequacy__GEO_Access.pdf</li> <li>HBL PI 220 July 2024 GEO Access Rpt Submission Cover.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE employs a systematic process to ensure compliance with the State's standards for access to care under 42 CFR §438.207, as well as standards at §438.68 and §438.206(c)(1). To achieve this, the MCE has established comprehensive policies and procedures that guide the development and management of its provider network. As detailed in the "Provider Network and Management - LA 47607" document, these policies mandate that Healthy Blue maintains a robust network capable of providing prompt and reasonable access to services appropriate to the urgency of the enrollees' needs. The document emphasizes considerations such as the enrolled population size, expected service utilization, geographic distribution of enrollees, and the accessibility of providers to ensure compliance and effective service delivery.</p> <p>The submission of network adequacy reports and analyses is crucial to demonstrate that the MCE maintains a network that is sufficient in number, mix, and geographic distribution to meet the health needs of the anticipated membership. The "Healthy Blue PI 220 July 2024 GEO Access Rpt Submission Cover" document thoroughly details the network adequacy from January 1 to June 30, 2024. This report highlights</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>compliance with key access metrics, such as the distance members must travel to receive care and the accessibility of providers across both urban and rural areas. By providing detailed data regarding the total number of providers, their specialties, and locations, the report affirms the MCE's capacity to offer an adequate range of preventive, primary, specialty, and long-term services and supports (LTSS) to its members. While there are no state-approved exceptions regarding network adequacy, the reports acknowledge limitations due to the diminishing availability of certain provider types in specific areas. The MCE has clearly communicated these challenges to the state, as documented in "Standard V_PH_Ntwk_Adequacy_GEO_Access.pdf," highlighting ongoing efforts to address these gaps and maintain compliance with state standards. This document showcases Healthy Blue's commitment to proactive communication and transparency about network challenges, demonstrating a comprehensive understanding of potential service interruptions due to unforeseen provider shortages. Additionally, the MCE is required to ensure adequate capacity through a formal process of attestation, as outlined in the contractual GEO Access Standards. This assurance involves submitting attestation upon contract execution and whenever significant operational changes might affect service capacity, thus maintaining accountability and readiness to meet member needs. The integration of robust policies, detailed reporting, and transparent communication exemplifies the MCE's structured approach to meeting its regulatory obligations and maintaining network adequacy. These documents comprehensively satisfy the requested elements by illustrating how the MCE aligns its operations with regulatory expectations and serves its enrolled population effectively.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL's Time/Distance Checklist and Member-to-Provider Ratio Checklist were also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified.</p>		
<p><b>Required Actions:</b> The MCE must maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Refer to the Access Standards: Time/Distance Checklist and Member-to-Provider Ratio Checklist for specific areas of noncompliance.</p>		
Timing		
<p>14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following:</p> <ol style="list-style-type: none"> <li>a. At the time it enters into a contract with the State.</li> <li>b. On an annual basis.</li> <li>c. At any time there has been a significant change (as defined by the State) in the MCE's operations that</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State)</li> <li>• Assurances of adequate capacity and services submission to the State due to a significant change</li> </ul>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>would affect the adequacy of capacity in services, including:</p> <ul style="list-style-type: none"> <li>i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or</li> <li>ii. Enrollment of a new population in the MCE.</li> </ul> <p style="text-align: right;">42 CFR §438.207(c) 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• PNP_Provider Network and Management - LA 47607.pdf</li> <li>• HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>• PH_Ntwk_Adequacy__GEO_Access.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Narratives</li> <li>• V.14_Process and Responsibilities for the Development, Review and Submission of Regulatory Reports</li> <li>• V.14_Process and Responsibilities for the Development, Review and Submission of Regulatory Reports_screenshots</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE meets the requirements outlined in 42 CFR §438.207(b) by ensuring that documentation related to adequate capacity and services is submitted to the State at critical points: contract initiation, annually, and upon noticeable changes affecting the network. This strategy is detailed through various documents, which encompass policies, procedures, and capacity assurance reports.</p> <p>Healthy Blue demonstrates compliance with the requirement through a comprehensive set of internal policies and procedures that govern network adequacy and management, as detailed in the document 'Standard V_PNP_Provider Network and Management - LA 47607.pdf'. This document elaborates on the processes and standards Healthy Blue uses to design, monitor, and adjust its provider network. The policies ensure that enrollees have timely access to necessary services through a well-maintained provider network. These procedures are in line with the standards set forth in their agreements with the State and include elements like network provider agreement requirements, steps for handling material changes in the network, and ongoing monitoring to ensure compliance with network adequacy standards.</p> <p>Assurances of adequate capacity and services are documented in the report titled 'Standard V_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf'. This report includes semi-annual submissions of network adequacy, detailing provider-to-enrollee ratios, geographical coverage, and the recruitment of providers across the state to maintain compliance. It explicitly reflects that Healthy Blue has been proactive in its efforts both to secure network adequacy and to improve accessibility despite membership growth. The report covers the period from January</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>1, 2024, to June 30, 2024, and outlines efforts to meet network adequacy such as the expansion of provider recruitment and identifying areas that require improvement.</p> <p>Furthermore, the report from 'Standard V_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf' also addresses assurances due to significant changes in the network. It discusses the strategic adjustments undertaken in response to significant changes, such as the identification of provider deficiencies in various urban parishes, challenges in maintaining adequate specialty services in rural areas, and the plan to roll out Value Based Incentive Programs to enhance provider retention. This represents a direct submission to the State to address significant changes, ensuring the MCE adheres to the requirement of submitting these assurances whenever there is a significant change as defined by the State. Overall, the documents provide a thorough narrative of Healthy Blue's diligent approach to meeting state and federal regulations for managed care entities, demonstrating compliance through structured policies, strategic engagement of network expansion, and transparent communications with the State regarding network adequacy.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Exceptions Process		
<p>15. To the extent the State permits an exception to any of the provider-specific network standards,</p> <p>MCO:</p> <p>a. <i>The MCO must submit any requests for exceptions for distance or appointment accessibility standards in writing to LDH for approval. Such requests must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population.</i></p> <p>PAHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Network monitoring report(s)</li> <li>Exceptions requested by the MCE, if applicable</li> <li>Exceptions approved by the State, if applicable</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>PNP_Provider Network and Management - LA 47607.pdf</li> <li>HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>PH_Ntwk_Adequacy__GEO_Access.pdf</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <p>a. <i>Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.</i></p> <p style="text-align: right;">42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b)</p> <p>MCO Contract: 2.9.5; 2.9.5.2 PAHP Contract: 2.6.1.8; 2.6.2.6 PIHP Contract: 6.3.1.1.3</p>		
<p><b>MCE Description of Process:</b> The MCE adheres to the state’s requirements regarding exceptions to provider-specific network standards through structured policies and procedures, network monitoring reports, and ongoing communication with state health departments.</p> <p>The MCE’s approach to managing exceptions to network standards is governed by a comprehensive set of policies and procedures, as outlined in 'Standard V_PNP_Provider Network and Management - LA 47607.pdf'. These policies emphasize the importance of maintaining a sufficient provider network that meets accessibility standards, and they detail the process for communicating with the Louisiana Department of Health (LDH) in case of any significant network changes. According to the document, the MCE is responsible for designing a network that considers geographic location, accessibility for enrollees with disabilities, and compliance with local provider licensing requirements. A critical aspect is the proactive engagement in network development and management, ensuring prompt and accessible service delivery.</p> <p>Despite the rigorous monitoring and compliance efforts, the document 'Standard V_PH_Ntwk_Adequacy__GEO_Access.pdf' reflects that the MCE has not submitted any requests for exceptions to accessibility standards, even when faced with provider shortages in rural areas. This document contains a comprehensive network monitoring report from July 11, 2024, detailing provider accessibility statistics and highlighting areas with potential access issues. It transparently identifies that while high accessibility rates are achieved in urban areas, rural areas face a significant lack of providers, making it challenging to meet the state's accessibility standards. However, despite awareness of these gaps, formal exception requests have not been made, underscoring compliance with current expectations while acknowledging geographic challenges.</p> <p>The monitoring reports in the 'Standard V_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf' further support this narrative by outlining the network adequacy from Jan 1 to June 30, 2024. These reports include provider-to-enrollee ratios, geographic coverage analyses, and detailed plans for addressing network deficiencies. Notably, the MCE continues to recruit providers and enhance network adequacy across the state, particularly targeting areas marked as Health Professional Shortage Areas. The document emphasizes an ongoing commitment to network improvement and collaboration with state authorities to ensure comprehensive coverage for all members.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HBL staff members stated during the interview session that the MCE had no exceptions to any of the provider-specific network standards in 2024; therefore, HSAG has determined that this requirement is not applicable.		
<b>Required Actions:</b> No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
<b>Total</b>	Met	=	8	X	1	=	8
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
<b>Total Applicable</b>		=	14	<b>Total Score</b>		=	8

<b>Total Score ÷ Total Applicable</b>	=	<b>57%</b>
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## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
<b>Primary Care Physician Access Standards</b>		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)  MCO Contract: Attachment F PAHP Contract: 2.6.5.3.2; 2.6.5.3.3 PIHP Contract: NA	1. <i>MCO:</i> a. <i>PCP appointments are available as follows:</i> i. <i>Non-urgent sick primary care: 72 hours</i> ii. <i>Non-urgent routine primary care: 6 weeks</i> <i>PAHP:</i> a. <i>Primary dental care: within 30 days</i> b. <i>Follow-up dental services: within 30 days after assessment</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>a_LA CAID_ProviderManual_2023.pdf, page 16</li> <li>a_LA CAID_ApptAvailabilityAfterHours.pdf</li> <li>a_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul>		
<b>Specialty Care Physician Access Standards</b>		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)  MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. <i>MCO:</i> a. <i>For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide:</i> b. <i>Specialist appointments: one month</i> c. <i>Non-urgent routine behavioral health care: 14 days</i> d. <i>Urgent non-emergency behavioral health care: 48 hours</i> e. <i>ASAM Level 3.3, 3.5, and 3.7: 10 business days</i> f. <i>Residential withdrawal management: 24 hours when medically necessary</i> g. <i>Psychiatric Residential Treatment Facility (PRTF): 20 calendar days</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p><i>PAHP:</i></p> <ul style="list-style-type: none"> <li>a. <i>Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:</i> <ul style="list-style-type: none"> <li>i. <i>Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;</i></li> <li>ii. <i>Primary dental care: within 30 days</i></li> <li>iii. <i>Follow-up dental services: within 30 days after assessment</i></li> </ul> </li> </ul> <p><i>PIHP:</i></p> <ul style="list-style-type: none"> <li>a. <i>Urgent non-emergency behavioral health care: 48 hours</i></li> </ul>	
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• a_LA CAID_ProviderManual_2023.pdf, page 19</li> <li>• a_LA CAID_ApptAvailabilityAfterHours.pdf</li> <li>• a_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul>	
Hospital and Emergency Services Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: 2.6.5.3 PIHP Contract: 6.3.1.2.2.1</p>	<p>3. <i>MCO:</i></p> <ul style="list-style-type: none"> <li>a. <i>Emergency care: 24 hours, 7 days/week within one hour of request</i></li> <li>b. <i>Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request</i></li> <li>c. <i>After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes</i></li> </ul> <p><i>PAHP:</i></p> <ul style="list-style-type: none"> <li>a. <i>Urgent care services – within twenty-four (24) hours of a request for services that do not require prior authorization and within forty-eight (48) hours for a request for services that do require prior authorization;</i></li> </ul> <p><i>PIHP:</i></p> <ul style="list-style-type: none"> <li>a. <i>Emergent care: 24 hours, 7 days/week within one hour of request</i></li> </ul>	<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/></p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
	<p>b. <i>Emergent, crisis or emergency services must be available at all times.</i></p> <p>c. <i>Urgent care: 24 hours, 7 days/week within 48 hours of request</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>a_LA CAID_ProviderManual_2023.pdf, page 19</li> <li>a_LA CAID_ApptAvailabilityAfterHours.pdf</li> <li>a_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> <li>a_LA Q4 2024 After Hours Final Data File.xlsx</li> </ul>	
Prenatal Care and Family Planning Access Standards		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA</p>	<p>4. <i>MCO:</i></p> <p>a. <i>OB/GYN care for pregnant women:</i></p> <p>i. <i>1st trimester: 14 days</i></p> <p>ii. <i>2nd trimester: 7 days</i></p> <p>iii. <i>3rd trimester: 3 days</i></p> <p>iv. <i>High risk pregnancy, any trimester: 3 days</i></p> <p>b. <i>Family planning appointments: 1 week</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>a_LA CAID_ProviderManual_2023.pdf, page 19</li> <li>a_LA CAID_ApptAvailabilityAfterHours.pdf</li> <li>a_LA Q4 2024 Appointment Availability Final Data File_with Sec Shop.xlsx</li> </ul>	<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/></p>
Office Waiting Times		
<p>42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<p>5. <i>MCO:</i> <i>PAHP:</i> <i>PIHP:</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>N/A</li> </ul>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/></p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
<b>Primary Care</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i> 2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000</i>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy__GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
<b>Hospitals</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: None PAHP Contract: None PIHP Contract: None	3. <i>Acute Inpatient Hospitals</i>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy__GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
<b>Ancillary</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None	4. <i>Laboratory</i> 5. <i>Radiology</i> 6. <i>Pharmacy</i> 7. <i>Hemodialysis Centers</i>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> </ul>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
PIHP Contract: None	<ul style="list-style-type: none"> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	
Specialty Care		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	8. <i>OB/GYN: 1:10,000</i> 9. <i>Allergy/Immunology: 1:100,000</i> 10. <i>Cardiology: 1:20,000</i> 11. <i>Dermatology: 1:40,000</i> 12. <i>Endocrinology and Metabolism: 1:25,000</i> 13. <i>Gastroenterology: 1:30,000</i> 14. <i>Hematology/Oncology: 1:80,000</i> 15. <i>Nephrology: 1:50,000</i> 16. <i>Neurology: 1:35,000</i> 17. <i>Ophthalmology: 1:20,000</i> 18. <i>Orthopedics: 1:15,000</i> 19. <i>Otorhinolaryngology/Otolaryngology: 1:30,000</i> 20. <i>Urology: 1:30,000</i>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
Linkage Ratio Standards		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	21. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500</i>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<b>22. Adult Physician Extenders: 1:1,000</b>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<b>23. Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500</b>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<b>24. Pediatric Physician Extenders: 1: 1,000</b>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>b_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>b_PH_Ntwk_Adequacy_GEO_Access.pdf</li> <li>b_0220_Network_Adequacy_July Semi Annual.xlsx</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Access Standards: Time/Distance Checklist**

Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
<b>Primary Care</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: 2.6.2.6.1 PIHP Contract: None	<ol style="list-style-type: none"> <li>1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> <li>a. <i>Rural Parishes: 30 miles</i></li> <li>b. <i>Urban Parishes: 10 miles</i></li> </ol> </li> <li>2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):</i> <ol style="list-style-type: none"> <li>a. <i>Rural Parishes: 30 miles</i></li> <li>b. <i>Urban Parishes: 10 miles</i></li> </ol> </li> <li>3. <i>Primary Dental Services:</i> <ol style="list-style-type: none"> <li>a. <i>Rural Parishes: 30 miles one-way</i></li> <li>b. <i>Urban Parishes: 10 miles</i></li> </ol> </li> </ol>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Standard Vc_0220_Network_Adequacy_July Semi Annual.xlsx</li> <li>• Standard Vc_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>• Standard Vc_PH_Ntwk_Adequacy__GEO_Access.pdf</li> </ul>		
<b>Hospitals</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<ol style="list-style-type: none"> <li>4. <i>Acute Inpatient Hospitals</i> <ol style="list-style-type: none"> <li>a. <i>Rural Parishes: 30 miles</i></li> <li>b. <i>Urban Parishes: 10 miles</i></li> </ol> </li> </ol>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• c_0220_Network_Adequacy_July Semi Annual.xlsx</li> <li>• c_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>• c_PH_Ntwk_Adequacy__GEO_Access.pdf</li> </ul>		



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
<b>Ancillary</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	5. <i>Laboratory:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i>  6. <i>Radiology:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 20 miles</i>  7. <i>Pharmacy:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>  8. <i>Hemodialysis Centers:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_0220_Network_Adequacy_July Semi Annual.xlsx</li> <li>c_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>c_PH_Ntwk_Adequacy_GEO_Access.pdf</li> </ul>	
<b>Specialty Care</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: 2.6.2.6.2 PIHP Contract: None	9. <i>OB/GYN:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>  10. <i>Allergy/Immunology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>  11. <i>Cardiology:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

Standard V—Access Standards: Time/Distance Checklist	
Reference	Required Components
	<p>12. <i>Dermatology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>13. <i>Endocrinology and Metabolism:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>14. <i>Gastroenterology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>15. <i>Hematology/Oncology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>16. <i>Nephrology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>17. <i>Neurology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>18. <i>Ophthalmology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>19. <i>Orthopedics:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul> <p>20. <i>Otorhinolaryngology/Otolaryngology:</i></p> <ul style="list-style-type: none"> <li>a. <i>Rural Parishes: 60 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ul>



**Louisiana Department of Health  
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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<p>21. <i>Urology:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>22. <i>Psychiatrists:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 30 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 15 miles</i></p> <p>23. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>24. <i>Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 60 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 60 miles</i></p> <p>25. <i>Specialty Dental Services</i></p> <p style="margin-left: 20px;">a. <i>Travel distance shall not exceed 60 miles one-way from the enrollee’s place of residence for at least 75% of enrollees.</i></p>	
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>c_0220_Network_Adequacy_July Semi Annual.xlsx</li> <li>c_HBL PI 220 July 2024 GEO Access Rpt Submission Cover_.pdf</li> <li>c_PH_Ntwk_Adequacy__GEO_Access.pdf</li> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
Licensed Mental Health Specialists		
<p>42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract</p>	<p>26. <i>Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)</i></p> <p style="margin-left: 20px;">a. <i>Rural Parishes: 30 miles</i></p> <p style="margin-left: 20px;">b. <i>Urban Parishes: 15 miles</i></p>	<p>Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/></p>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	27. <i>PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization</i> <i>a. Rural and Urban Parishes: 200 miles</i>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	28. <i>ASAM Level 1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 29. <i>ASAM Level 2.1:</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i> 30. <i>ASAM Level 2WM:</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
Substance Use Residential Treatment Facilities (adult)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	31. <i>ASAM Levels 3.1</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
Contract  MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	32. <i>ASAM Levels 3.3</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 33. <i>ASAM Levels 3.5</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 30 miles</i> 34. <i>ASAM Levels 3.2-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 35. <i>ASAM Level 3.7</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 36. <i>ASAM Level 3.7-Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	37. <i>ASAM Level 3.1</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 38. <i>ASAM Level 3.2 Withdrawal Management</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i> 39. <i>ASAM Level 3.5</i> <i>a. Rural Parishes: 60 miles</i> <i>b. Urban Parishes: 60 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
<b>Psychiatric Inpatient Hospital Services</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	40. <i>Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit</i> <i>a. Rural Parishes: 90 miles</i> <i>b. Urban Parishes: 90 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
<b>Behavioral Health Rehabilitation Services</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	41. <i>Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
<b>Behavioral Health Specialists</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	42. <i>For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 15 miles</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Time/Distance Checklist		
Reference	Required Components	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.1; 6.3.1.1.1.2	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	43. <i>For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):</i> <ol style="list-style-type: none"> <li>a. <i>Rural Parishes: 90 miles</i></li> <li>b. <i>Urban Parishes: 60 miles</i></li> </ol>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>c_HBL PRLA00007R_348_BEHAVIORAL_HEALTH_ACCESS05.15.2024.pdf</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<b>Care Coordination and Services</b>		
<i>Under 42 CFR §438.208(a)(2) For PIHPs and PAHPs, the State determines, based on the scope of the entity's services, and on the way the State has organized the delivery of managed care services, whether a particular PIHP or PAHP is required to implement mechanisms for identifying, assessing, and producing a treatment plan for an individual with special health care needs, as specified in 42 CFR §438.208(c).</i>		
<p>1. The MCE ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member.</p> <p style="margin-left: 20px;">a. The member is provided information on how to contact their designated person or entity.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(1) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Care management program description</li> <li>Member materials, such as the member handbook or member notice</li> <li>Primary care provider (PCP) assignment algorithm</li> <li>Screenshot of member identification (ID) card</li> <li>Screenshot of fields designating the assigned PCP and assigned case manager</li> <li>HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,4,6_Continuity of Care - LA.pdf, Page 2</li> </ul> </li> <li>Care Management Program Description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, Page 48, Access to Case Management Associate section</li> </ul> </li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• PCP Assignment Algorithm               <ul style="list-style-type: none"> <li>– 1_PCP Assignment Algorithm_LA.docx</li> </ul> </li> <li>• Member Identification (ID) Card               <ul style="list-style-type: none"> <li>– 1_Member Identification Card.docx, entire document</li> </ul> </li> <li>• Screenshot of fields designating the assigned PCP and assigned case manager:               <ul style="list-style-type: none"> <li>– 1_Screenshot of assigned PCP and assigned CM, Page 1, Entire Page</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><i>Policies and Procedures:</i></b></p> <p><b>Continuity of Care:</b> This policy and procedure outlines the entire Continuity of Care process. Including, how to make sure members have designated contacts within the health plan.</p> <p><b><i>Care Management Program Description:</i></b></p> <p><b>2024 Complex Case Management Program Description:</b> This document outlines the procedure for a member to access a case management staff member upon enrollment in case management. The case manager will provide their contact number and business hours to the member. Should the member need assistance from the health plan outside the case manager's availability, they may reach out to member services, utilize our 24/7 nurse line and BH crisis line. These contact numbers are also provided to members at the time of their enrollment in the case management program.</p> <p><b><i>PCP Assignment Algorithm:</i></b></p> <p><b>PCP Assignment Algorithm:</b> This document includes the logic used to assign PCPs for LA members based on factors such as gender, age, language, driving distance, and quality ratings along with the basic business rules for validating provider network during the assignment period.</p> <p><b><i>Member Identification (ID) Card:</i></b></p> <p><b>Member ID Card:</b> Screenshot of a sample member ID card that is provided to the members.</p> <p><b><i>Screenshots of fields designating the assigned PCP and assigned CM:</i></b></p>		



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<p><b>Screenshot of assigned PCP and assigned CM:</b> This image captures a screenshot of our Member360 system, which offers an overview of the members' medical requirements. A key feature of this system is its ability to display the primary care provider (PCP) and the assigned case manager (CM), enabling any member of the health plan to contact them regarding any issues or concerns that may arise.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>2. The MCE coordinates the services the MCE furnishes to the member:</p> <ul style="list-style-type: none"> <li>a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.</li> <li>b. With the services the member receives from any other MCO, PIHP, or PAHP.</li> <li>c. With the services the member receives in fee-for-service (FFS) Medicaid.</li> <li>d. With the services the member receives from community and social support providers.</li> </ul> <p>MCO:</p> <ul style="list-style-type: none"> <li>a. <i>Coordinate care between network PCPs and specialists, including specialized behavioral health providers;</i></li> <li>b. <i>Coordinate care for out-of-network services, including specialty care services;</i></li> <li>c. <i>Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;</i></li> <li>d. <i>Coordinate with the court system and State child-serving agencies with regard to court- and agency-</i></li> </ul>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Care management program description</li> <li>• Transition of care program</li> <li>• Workflow for coordinating with other MCOs/PIHPs/PAHPs</li> <li>• Workflow for coordinating with FFS</li> <li>• Workflow for coordinating with community and social support resources</li> <li>• HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,4,6_Continuity of Care - LA.pdf, Pages 2 and 3</li> <li>– 2,8-11_Tiered Case Management – LA.docx, page 3, Transitional case management section</li> </ul> </li> <li>• Care Management Program Description:</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p><i>involved youth, to ensure that appropriate services can be accessed.</i></p> <p><b>PAHP:</b></p> <p>a. Coordination with the enrollee’s MCO:</p> <p style="margin-left: 20px;">i. <i>for oral health issues exceeding the coverage of the Contract;</i></p> <p style="margin-left: 20px;">ii. <i>for transportation to and from covered dental services; and</i></p> <p style="margin-left: 20px;">iii. <i>regarding value-added dental benefits offered by the enrollee’s MCO.</i></p> <p><b>PIHP:</b></p> <p>a. <i>Coordination with the Office of Citizens with Developmental Disabilities (OCDD) for the behavioral health needs of the intellectual and developmental disabilities (I/DD) co-occurring population.</i></p> <p>b. <i>Coordinate care for out-of-network services.</i></p> <p>c. <i>Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.</i></p> <p>d. <i>Coordinate timely with Integrated Medicaid Managed Care Programs and the member’s family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.3; 2.8.1.4.4; 2.8.1.4.5; 2.8.1.4.10 PAHP Contract: 2.4.7.1; 2.4.6.2.1.3; 2.4.6.2.1.4; 2.4.6.2.1.5 PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7</p>	<ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 47, Social Determinants of Health Section</li> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 45, Coordination of Care</li> <li>• Workflow for coordination with community and social support resources:               <ul style="list-style-type: none"> <li>– 2_Women, Infants and Children (WIC)-LA.docx, page 2 Bullet 4</li> </ul> </li> <li>• Workflows for coordination with other MCOs/ PIHPs/ PAHPS and Transition of Care Program:               <ul style="list-style-type: none"> <li>– 2_Transition of Care Workflow 20230214.docx, entire document</li> <li>– 2_LA TOC File Exchange Desktop Process.docx, entire document</li> </ul> </li> </ul>	



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<p><b>MCE Description of Process:</b>  <b><i>Policies and Procedures:</i></b>  <b>Continuity of Care- LA:</b> This policy and procedure outlines the entire Continuity of Care process. Including, how coordination amongst external entities is achieved.  <b>The Tiered Case Management-LA :</b> Details the procedures implemented by the case management department for members categorized under different tiers. One specific tier is Transitional Case Management. In this tier, members are actively engaged during and after their inpatient stay to help address any gaps identified in their discharge plan. These gaps may include, but are not limited to, the ordering of durable medical equipment (DME) supplies, coordination of therapy appointments, scheduling of specialist and follow-up appointments, arranging transportation for follow-up visits, and addressing other social determinants of health that may affect the member's well-being. The case manager works collaboratively with the member and hospital staff to manage these tasks efficiently and promptly.  <b><i>Care Management Program Description:</i></b>  <b>2024 Complex Case Management Program Description:</b> This document details the team's process for coordinating efforts among multiple entities. When a member is enrolled in case management, the case manager facilitates referrals to community and social support services. We utilize a tool called FindHelp to locate appropriate referral resources, and this information is communicated to the member via telephone, email, or text. Additionally, case management supports members admitted to inpatient settings by assisting with discharge planning. We conduct follow-up calls to confirm that the member has scheduled their 7-day follow-up appointments. If not, we assist in arranging these appointments. Furthermore, we aid with referrals required at the time of discharge, including those for durable medical equipment (DME) and therapy services.  <b><i>Workflow for Community and Social Supports:</i></b>  <b>Women, Infants and Children (WIC)- LA:</b> This document serves as an example of our referral process to connect members with our WIC partners. When a member is identified as being pregnant or a young mother in need of support, the case manager will assist the member in completing a referral to WIC. This effort aims to address and close any existing gaps in the member's support network.  <b><i>Workflow for coordination with other MCOs/PHIPs/PHAPs and Transition of Care:</i></b>  <b>Transition of Care Workflow 20230213:</b> Workflow that details the automation process of transition of care files in and out of the Health Plan.  <b>LA TOC File Exchange Desktop Process:</b> Desktop Process that details the automation process of transition of care files in and out of the Health Plan.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



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<b>Required Actions:</b> No action required.		
<p>3. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>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 of care. These procedures shall address Enrollees 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.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8</p>	<p><b>HSAG Required Evidence:</b></p> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,4,6_ Continuity of Care- LA, Page 5</li> </ul> </li> <li>• Care Management Program Description:</li> <li>• 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 45</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><b>Policies and Procedures:</b></p> <p><b>Continuity of Care:</b> This policy and procedure outlines the entire Continuity of Care process. Including, how coordination amongst external entities is achieved.</p> <p><b>Care Management Program Description:</b></p> <p><b>2024 Complex Case Management Program Description:</b> This document outlines the process by which the case management team assists members in connecting with specialists, including behavioral health services, when such a need is identified. The team will research providers who are accepting new patients, provide this information to the members, and assist with appointment scheduling if necessary. Additionally,</p>		



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the team will follow up with the members to ensure the services meet their needs. If a member does not have a primary care provider (PCP), the team will follow the same steps to facilitate a connection.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Information Sharing		
<p>4. The MCE shares with the State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities</p> <p>MCO: a. <i>Upon written request</i></p> <p style="text-align: right;">42 CFR §438.208(b)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Workflow for sharing assessment results with the State</li> <li>• Workflow for sharing assessment results with other MCOs/PIHPs/PAHP</li> <li>• Care management program description</li> <li>• Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,4,6_Continuity of Care – LA.pdf, Page 2</li> </ul> </li> <li>• Care Management Program Description:               <ul style="list-style-type: none"> <li>– Care Management Program Description: 2024 Complex Case Management Program Description, Page 45hs</li> </ul> </li> <li>• Workflows for sharing assessment results:               <ul style="list-style-type: none"> <li>– TOC- Blank Checklist.doc, entire document</li> </ul> </li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p><b>MCE Description of Process:</b>  <b>Policies and Procedures:</b>  <b>Continuity of Care- LA:</b> This policy and procedure outlines the overarching coordination of care section and explains how we coordinate care with providers, other MCO’s and state partners. If a state partner or other MCO was to request the assessment results from a member, Healthy Blue would provide this information to the requesting entity.  <b>Care Management Program Description:</b>  <b>2024 Complex Case Management Program Description:</b> This document provides information on how Healthy Blue provides coordination of care with other providers, MCO’s and pertinent entities.  <b>Workflow for sharing assessment results:</b>  <b>TOC-Blank Checklist:</b> This document is a blank copy of how we request or return information between MCO’s and the state usually via e-mail.  <b>Three examples:</b>            We have not received a request from the state or from other MCOs/ PIHPS and PAHPs for 2024. Therefore, we are unable to provide examples for this request.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>5. The MCE ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.  <div style="text-align: right; margin-right: 50px;">           42 CFR §438.208(b)(5)            42 CFR §457.1230(c)         </div>           MCO Contract: 2.8.1.4.7            PAHP Contract: 2.4.8.1; 2.4.8.2; 2.4.8.3.1            PIHP Contract: 16.15</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Care management program description- quality program description.</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices-</li> </ul>	<p> <input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA         </p>



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	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policy and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,4,6_ Continuity of Care-LA.docx, page 2</li> </ul> </li> <li>• Care Management Program Description:               <ul style="list-style-type: none"> <li>– 2024 Case Management Program Description, Page 54, Confidentiality</li> <li>– 5,6_ LA 2024 QM Program Description FINAL APPROVED.pdf, page 36</li> </ul> </li> <li>• Provider Materials:               <ul style="list-style-type: none"> <li>– Standard VI_Healthy Blue Provider Manual_2023.pdf, pages 88-89, 97-100</li> </ul> </li> <li>• Medical Record Review Results:               <ul style="list-style-type: none"> <li>– 5- Q4 2024 Utilization Management Medical Review Report; Entire Document</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><i><b>Policies and Procedures:</b></i></p> <p><b>Continuity of Care:</b> This policy and procedure outlines the entire Continuity of Care process. Including, how providers are notified and monitored that they are to maintain professional standards while conducting business with our members.</p> <p><i><b>Care Management Program Description:</b></i></p> <p><b>2024 Case Management Program Description:</b> This document explains that the case management team is committed to maintaining the confidentiality of members' information. It provides specific guidance on handling particular situations that may arise for a case manager, ensuring that all actions comply with privacy standards and protect member confidentiality.</p> <p><b>2024 QM Program Description FINAL Approved:</b> Document explain that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards.</p> <p><i><b>Provider Materials:</b></i></p> <p><b>Healthy Blue Provider Manual_2023:</b> Provider manual that is provided to providers that informs them that they are responsible for maintaining professional services while rendering services.</p>		



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<b>Medical Record Review Results:</b>		
<b>Q4 2024 Utilization Management Medical Record Review Report:</b> Report that provides the results for the audits performed on providers.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>6. The MCE ensures that in the process of coordinating care, each member’s privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E</p> <p>MCO Contract: 2.8.2.2.4; 2.9.11.5.1.7; 6.22 PAHP Contract: 2.1.4.1; 2.6.9.5.21 PIHP Contract: 20.12</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Care management program description</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 1,2,6_Continuity of Care – LA.pdf, Page 3</li> </ul> </li> <li>• Care Management Program Description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, Page 54, Confidentiality</li> <li>– 5,6_LA 2024 QM Program Description FINAL APPROVED.pdf, page 36</li> </ul> </li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <p><b>Policies and Procedures:</b></p> <p><b>Continuity of Care- LA:</b> This policy and procedure outlines the entire Continuity of Care process. It discusses how we ensure that all members are coordinated care for appropriate services within applicable laws.</p> <p><b>Care Management Program Description:</b></p> <p><b>2024 Complex Case Management Program Description:</b> This document explains that the case management team is committed to maintaining the confidentiality of members' information. It provides specific guidance on handling particular situations that may arise for a case manager, ensuring that all actions comply with privacy standards and protect member confidentiality.</p> <p><b>2024 QM Program Description:</b></p>		



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<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<b>Initial Health Risk Screening</b>		
<p>7. The MCE makes a best effort to conduct an initial screening of each member’s needs within MCO:</p> <p style="margin-left: 20px;">a. 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. <i>The MCO shall attempt to conduct, and document its efforts to conduct, the health needs assessment on at least three (3) different occasions, at different times of the day and on different days of the week.</i></p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>The DBPM shall contact each new enrollee at least twice, if necessary, within ninety (90) days of the enrollee’s enrollment to conduct an initial screening of the enrollee’s needs and to offer to schedule the enrollee’s initial appointment with the primary dental provider (PDP), which should occur within one hundred eighty (180) days of enrollment.</i></p> <p style="text-align: right; margin-left: 200px;">42 CFR §438.208(b)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Care management program description</li> <li>Initial screening template</li> <li>Initial screening tracking and monitoring mechanisms and subsequent results/reports</li> <li>HSAG will also use the results of the case file reviews</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures:               <ul style="list-style-type: none"> <li>– 7_Case Management- LA.pdf, Page 5, Health Needs Assessment Section</li> </ul> </li> <li>Care Management Program Description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf</li> </ul> </li> <li>Initial Screening Template:               <ul style="list-style-type: none"> <li>– 7_HIP Welcome Call.docx Entire Document</li> <li>– 7_LA Member Welcome Call Questions 2024.xlsx, Row 1 (highlighted in yellow)</li> </ul> </li> <li>Initial Screening tracking and monitoring mechanisms and subsequent results/reports:</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<ul style="list-style-type: none"> <li>– 7_LA Member Welcome Call 2024.xlsx, Entire Document</li> <li>– 7_HIP LA Welcome Call 2024.xlsx, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b>Case Management- LA:</b> This document outlines the policy and procedure for our Health Needs Assessment (HNA) process. It offers a high-level overview of how the health plan conducts welcome calls for all new members. These welcome calls include an initial screening process. Members also receive a screening questionnaire via mail, which is available at any time on our website.</p> <p>Care Management Program Description:</p> <p><b>Initial Screening Template:</b></p> <p><b>HIP Welcome Call:</b> This document presents the questions posed to members during welcome calls as part of a trial period for a new system we are testing.</p> <p><b>LA Member Welcome Call Questions 2024:</b> Shows the questions that are being asked of our members that receive a welcome call.</p> <p><b>Initial Screening Tracking and Monitoring:</b></p> <p><b>LA Member Welcome Call 2024:</b> This document outlines the members contacted during the Health Insurance Portability (HIP) Welcome Call Outreaches. This process was used on a short-term basis as we work towards implementing a new and more efficient method for documenting and retrieving welcome call data. Some irregularities were identified within the system; therefore, we temporarily reverted to the previous method while these issues are being resolved. Our goal is to have the new process fully implemented by the third quarter of 2025.</p> <p><b>HIP LA Welcome Call 2024:</b> This document describes the outreach efforts conducted for welcome calls for new members, aiming to obtain a completed screener.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that HBL had policies, procedures, and mechanisms to conduct the initial health needs assessment (HNA); however, results from the virtual case management performance evaluation (CMPE) file review demonstrated noncompliance with timely completion of the initial HNA.</p>		
<p><b>Required Actions:</b> The MCE must conduct an initial screening of each member’s needs within 90 calendar days of the effective date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the HNA on at least three different occasions, at different times of the day and on different days of the week. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of the initial</p>		



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<p>HNA. This process must include HNA time frame monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.</p>		
Comprehensive Assessment		
<p>8. The MCE implements mechanisms to comprehensively assess each Medicaid member identified by the State and identified to the MCE by the State as needing long-term services and supports (LTSS) or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.</p> <p>a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate.</p> <p>PAHP:</p> <p>a. <i>The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.</i></p> <p style="text-align: right;">42 CFR §438.208(c)(2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Care management program description</li> <li>• Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS</li> <li>• Comprehensive assessment template</li> <li>• HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, page 3, Case Management Assessment</li> <li>– 2,8-11_Tiered Case Management – LA.docx, page 7, Definitions</li> </ul> </li> <li>• Care Management Program Description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, Page 38, Section Assessment</li> </ul> </li> <li>• Documentation defining members with special healthcare needs:               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, page 7, Definitions</li> </ul> </li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• Comprehensive Assessment Template:               <ul style="list-style-type: none"> <li>– 8_Complex Case Management Adult- Initial Assessment, Entire Document</li> <li>– 8_Complex Case Management Pediatric Initial Assessment, Entire Document</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b>  <b><i>Policies and Procedures:</i></b>  <b>Tiered Case Management-LA:</b> This document outlines the policy for identifying members with Special Health Care Needs. Identification occurs on a monthly basis, and outreach efforts are made to conduct assessments with these members. Please note that this process does not include the identification of members for Long-Term Services and Supports (LTSS), as our services do not encompass LTSS.  <b><i>Care Management Program Description:</i></b>  <b>2024 Complex Case Management Program Description:</b> This document provides a high-level overview of the assessment process for members enrolled in case management. These assessments are conducted for members with Special Health Care Needs, as well as for those who may not meet the formal definition of such needs.  <b><i>Document defining members with Special HealthCare Needs:</i></b>  <b>Tiered Case Management- LA:</b> This policy and procedure document clearly defines the criteria for members who qualify as having Special Health Care Needs (SHCN). It serves as a guide for all case managers, ensuring that members with SHCN are appropriately identified and marked within the case management system.  <b><i>Comprehensive Assessment Template:</i></b>  <b>Complex Case Management Adult:</b> This is a series of screenshots illustrating the complex assessment provided to adult members who consent to participate in case management.  <b>Complex Case Management Pediatric:</b> This series of screenshots showcases the assessment given to adolescent members identified as having Special Health Care Needs and who have consented to receive this assessment.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that HBL had policies, procedures, and mechanisms to conduct initial comprehensive assessment and timely in-person reassessments; however, results from the CMPE file review demonstrated noncompliance with completion of timely in-person reassessments for Tier 2 and Tier 3 enrollees.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>Required Actions:</b> The MCE must conduct an in-person quarterly reassessment of each member’s needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the in-person assessment on at least three different occasions, at different times of the day and on different days of the week and/or provide documentation of the member’s refusal to complete the reassessment in person. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of in-person reassessments. This process must include reassessment monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.</p>		
Treatment/Service Plan		
<p>9. The MCE produces a treatment or service plan for members who require LTSS and, if the State requires, members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring.</p> <p style="text-align: right;">42 CFR §438.208(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Care management program description</li> <li>• Person centered treatment plan template</li> <li>• HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, page 4, Individual Plan of Care (POC)</li> </ul> </li> <li>• Care Management Program Description               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, pages 41 &amp; 42, Care Plan Section</li> </ul> </li> <li>• Person Centered Plan of Care Template:               <ul style="list-style-type: none"> <li>– 9_Person Centered Plan of Care Template.docx, entire document</li> </ul> </li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b></p> <p><i>Policies and Procedures:</i></p> <p><b>Tiered Case Management- LA:</b> This policy outlines the person-centered plan of care, which is developed once a member has consented to case management. The plan is collaboratively completed with the member and/or their representatives, focusing on the member's unique goals, barriers, progress, and outcomes. It is specifically designed for members with Special Health Care Needs, noting that Long-Term Services and Supports (LTSS) are not available in our state.</p> <p><i>Care Management Program Description:</i></p> <p><b>2024 Complex Case Management Program Description:</b> This program description provides a high-level overview of the person-centered plan of care, detailing its components, the responsible parties for its development, and the timeline for its completion. It addresses all members who may receive a plan of care, including those with and without Special Health Care Needs. The description does not cover Long-Term Services and Supports (LTSS), as LTSS is not a benefit provided under Louisiana Medicaid.</p> <p><i>Person Centered Plan of Care Template:</i></p> <p><b>Person Centered Plan of Care Template:</b> This collection of screenshots illustrates the appearance of the plan of care within our case management system. The plan of care is an ongoing process that evolves as the member's needs are addressed, and new needs are identified. These plans of care apply to all members participating in case management, including those with Special Health Care Needs. Similar to other aspects, it does not apply to Long-Term Services and Supports (LTSS), as this is not an applicable population within Louisiana.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>10. The treatment or service plan is:</p> <ul style="list-style-type: none"> <li>a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member.</li> <li>b. Developed by a person trained in person-centered planning using a person-centered planning process and plan as defined in 42 CFR §441.301(c)(1) and (2) for LTSS treatment or service plans.</li> </ul>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Case management program description</li> <li>• Staff qualifications for developing care plans and service plans (e.g., job description)</li> <li>• Service plan approval process</li> <li>• Mechanisms to actively involve the member and the member's formal and informal supports in the development of the treatment plan</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p>c. Approved by the MCE in a timely manner, if this approval is required by the MCE.</p> <p>d. In accordance with any applicable State quality assurance and utilization review standards.</p> <p style="text-align: right;">42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3</p>	<ul style="list-style-type: none"> <li>• Mechanisms to actively involve the member’s PCP (and any other providers involved in the member’s care) in the development of the treatment plan</li> <li>• HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policies and Procedures:               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, page 4, Individual Plan of Care Section</li> </ul> </li> <li>• Case Management Program Description               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 42</li> </ul> </li> <li>• Staff qualifications for developing care plans and service plans               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, pages 16 &amp; 18</li> <li>– 10_BH CM Job Description, Entire Document.docx</li> <li>– 10_PH CM Job Description.docx</li> </ul> </li> <li>• Service Plan Approval Process:               <ul style="list-style-type: none"> <li>– Not Applicable as we don’t have LTSS</li> </ul> </li> <li>• Mechanisms to actively involve the member and the member’s formal and informal supports in the development of the person centered plan of care:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 42, Collaboration section</li> </ul> </li> </ul>	



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 43 Collaborative Input Section</li> <li>– 2,8-11_Tiered Case Management – LA.docx, page 4</li> <li>• Mechanisms to actively involve the members’ PCP (and other provider involved in the member’s care) of the plan of care:               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, pages 4 &amp; 5</li> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 43, Collaborative Input Section</li> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 44, Physician Communication Section</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b>            *Please note that treatment plans are not performed by the case management team as we do not have LTSS as a product in Louisiana. We do perform person-centered plans of care.*</p> <p><b>Policies and Procedures:</b></p> <p><b>Tiered Case Management-LA:</b> This policy outlines the process for creating a person-centered plan of care for members enrolled in case management. Once established, the plan of care is updated at specific intervals or whenever there is a change in the member's needs. It is important to note that, as Long-Term Services and Supports (LTSS) are not available in the state of Louisiana, treatment plans for LTSS are not part of this process.</p> <p><b>Case Management Program Description:</b></p> <p><b>2024 Complex Case Management Program Description:</b> This document provides detailed information about the specifics of the person-centered plan of care, including the qualifications required for staff members responsible for developing these plans. It should be noted that treatment plans are not applicable in the state of Louisiana due to the absence of Long-Term Services and Supports (LTSS).</p> <p><b>Staff qualifications for developing care plans:</b></p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>2024 Complex Case Management Program Description:</b> This document offers a high-level overview of the qualifications and job responsibilities required for case managers who conduct assessments and develop plans of care.</p> <p><b>BH CM Job Description:</b> This is a description of the elements of the BH CM job’s that are required to complete assessments and plans of care. These are listed upon the hiring process and provided to staff among enrollment. They may be changed as needs arise.</p> <p><b>PH CM Job Description:</b> This document details the various levels of case managers, along with the corresponding job descriptions for each role. It also outlines the qualifications required to attain each level.</p> <p><b>Service Plan Approval process:</b> This is not applicable to our plan as we do not serve LTSS members.</p> <p><b>Mechanisms to actively involve the member and the member’s formal and informal supports:</b></p> <p><b>2024 Complex Case Management Program Description:</b> This document provides a high-level overview of how members and their support systems are actively involved in the plan of care process. Members not only consent to the plan of care but also participate in its creation. During this process, the member's goals are reviewed, and progress is documented. If there are changes in the member's needs, the plan of care is updated accordingly to reflect these new requirements.</p> <p><b>Tiered Case Management- LA:</b> This document provides a high-level overview of how members and their support systems are actively involved in the plan of care process. Members not only consent to the plan of care but also participate in its creation. During this process, the member's goals are reviewed, and progress is documented. If there are changes in the member's needs, the plan of care is updated accordingly to reflect these new requirements.</p> <p><b>Mechanism to actively involve the members’ PCP:</b></p> <p><b>Tiered Case Management- LA:</b> The case management department makes diligent efforts to engage the member's primary care provider (PCP) and other specialists in developing a holistic plan of care. If these providers are unavailable, the plan of care is created at a minimum with direct input from the member.</p> <p><b>2024 Complex Case Management Program Description:</b> The case management department makes diligent efforts to engage the member's primary care provider (PCP) and other specialists in developing a holistic plan of care. If these providers are unavailable, the plan of care is created at a minimum with direct input from the member.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance in the development of plans of care (POCs) that are person-centered and include goals, risks, behavioral health, and supports.</p>		
<p><b>Required Actions:</b> No action required.</p>		



**Louisiana Department of Health  
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Requirement	Supporting Documentation	Score
<p>11. The treatment or service plan is reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member’s circumstances or needs change significantly, or at the request of the member per 42 CFR §441.301(c)(3).</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Care management program description</li> <li>Care plan and service plan review and revision tracking mechanism</li> <li>HSAG will also use the results of the case file reviews</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures:               <ul style="list-style-type: none"> <li>– 2,8-11_Tiered Case Management – LA.docx, pages 2-4</li> </ul> </li> <li>Care Management program description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 45</li> </ul> </li> <li>Care Plan review and revision tracking mechanism:               <ul style="list-style-type: none"> <li>– 11_Care Plan Progress.docx, entire document</li> </ul> </li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b></p> <p><b><i>Policies and Procedures:</i></b></p> <p><b>Tiered Case Management- LA:</b> This document outlines the policies regarding when updates to the plan of care are required. The Health Plan mandates updates to the plan of care based on the member's Tier level, with updates occurring at a minimum of every 12 months. Additionally, updates are made when there is a change in the member's level of care or when new needs are identified.</p> <p><b><i>Care Management Program Description:</i></b></p> <p><b>2024 Complex Case Management Program Description:</b> This document offers a high-level overview of the outreach attempts related to the plan of care. It includes a timeline for updates, detailing when they should occur, and specifies the key elements that should be incorporated into these updates.</p>		



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>Care Plan Review:</b>  <b>Care Plan Progress:</b> This series of screenshots demonstrates how we track the care plan and document the updates made.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.  <b>Recommendations:</b> Results from the virtual CMPE file review demonstrated overall compliance with timely updating of the POC; however, HSAG recommends that the MCE consider revisions to its internal processes to ensure timely revision of the POC when the enrollee’s circumstances or needs change significantly.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Direct Access to Specialists		
<p>12. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the MCE must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member’s condition and identified needs.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.208(c)(4) 42 CFR §457.1230(c)</p> <p>MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Care management program description</li> <li>Member materials, such as the member handbook or benefits grid</li> <li>Provider materials, such as the provider manual or provider contracts</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policies and Procedures:               <ul style="list-style-type: none"> <li>– 12_Standing Referral-LA.pdf, entire document</li> </ul> </li> <li>Care Management Program Description:               <ul style="list-style-type: none"> <li>– 1-3, 6-12_2024 Complex Case Management Program Description.pdf, page 40</li> </ul> </li> <li>Member materials, such as the member handbook or benefits grid:</li> </ul>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– 12_Healthy Blue Member Handbook, pages 23 and 63</li> <li>• Provider materials, such as the provider manual or provider contracts:               <ul style="list-style-type: none"> <li>– Standard VI_Healthy Blue Provider Manual_2023.pdf, pages 24-25</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b></p> <p><b><i>Policies and Procedures:</i></b></p> <p><b>Standing Referral-LA:</b> Policy that discusses the standing referral policy within Healthy Blue. It also discusses that a standing referral is not needed for Healthy Blue.</p> <p><b><i>Care Management Program Description:</i></b></p> <p><b>2024 Complex Case Management Program Description:</b> This document details the process for conducting assessments on members with Special Health Care Needs. If a member is identified as needing a provider, the case manager researches available providers in the member area and either supplies the member with this list or assists in scheduling an appointment through a three-way telephone call. The Managed Care Entity (MCE) has established robust mechanisms to ensure members with special health care needs have direct access to specialists, which is crucial for those requiring structured treatment plans or ongoing care monitoring.</p> <p><b><i>Member materials, such as the member handbook or benefits grid:</i></b></p> <p><b>Healthy Blue Member Handbook:</b> Informs members that a referral is not needed for any in-network services. It also discusses the process for out-of-network service referrals that may be needed.</p> <p><b><i>Provider materials, such as the provider manual or provider contracts:</i></b></p> <p><b>Standard VI_Healthy Blue Provider Manual:</b> Serves as the key document demonstrating compliance with these needs. It elaborates on the processes that enable direct access to specialists through provisions such as standing referrals and pre-approved visit limits tailored to members' specific conditions. This document incorporates detailed protocols that align with regulatory requirements, including comprehensive guidelines on referrals, communication between primary care providers (PCPs) and specialists, and the structured role of PCPs in coordinating specialist services. By detailing such mechanisms, the provider manual ensures that all members, especially those with special needs, can efficiently access and benefit from the specialist services essential to their care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element. The provider manual had a September 2023 copyright date. During the interview, the MCE confirmed the manual was applicable for the entire 2024 period under review, as HBL updates</p>		



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Requirement	Supporting Documentation	Score
and annual revisions occur late in the calendar year, and the 2023 version was updated for 2024 and approved by LDH in 2024, it would be applicable for the period of review.		
<b>Required Actions:</b> No action required.		

Results for Standard VI—Coordination and Continuity of Care							
<b>Total</b>	Met	=	10	X	1	=	10
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	12	<b>Total Score</b>	=	10	

<b>Total Score ÷ Total Applicable</b>	=	<b>83%</b>
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**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Standard VII—Coverage and Authorization of Services**

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Coverage</b>		
<p>1. The MCE:</p> <p>a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer.</p> <p>b. Ensures the services are furnished in an amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B.</p> <p>c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose.</p> <p style="margin-left: 40px;">42 CFR §438.210(a)(1-2) 42 CFR §438.210(a)(3)(i) 42 CFR §440.230 42 CFR §441 Subpart B 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.1; 2.4.1.2; 2.4.1.3 PAHP Contract: 2.4.1.4 PIHP Contract: 4.1.2; 4.1.7</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook and benefits grid</li> <li>Utilization Management (UM) program description</li> <li>Coverage guidelines/criteria</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1a: Healthy Blue Member Handbook: pgs 27-41 (includes table),</li> <li>1b: Healthy Blue Member Handbook: pg 88</li> <li>1c: Healthy Blue Member Handbook pg 88</li> <li>1, 1a, 1b, 1c: Healthy Blue Member Handbook, pg 28-41 (Coverage guidelines/criteria)</li> <li>1a-c: Utilization Management-LA Policy, pg 32</li> <li>1a-c: UM Program Description, pg 6 &amp; pg15</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue provides evidence of requirements in our policy, member handbook, and UM Program Description.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>2. The MCE may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Coverage guidelines/criteria</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2 Utilization Management-LA, pg 32</li> <li>2 UM Program Description, pg 17</li> <li>2 Healthy Blue Member Handbook, pg 28-41 (Coverage guidelines/criteria)</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue’s Utilization Management-LA Policy, UM Program Description, and Healthy Blue Member Handbook demonstrate the processes in place on adverse decisions</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>3. The MCE may place appropriate limits on a service on the basis of criteria applied under the State plan, such as medical necessity, or on utilization control procedures, provided that:</p> <p>MCO, PAHP, and PIHP:</p> <p>a. The services furnished can reasonably achieve their purpose.</p> <p>MCO and PIHP:</p> <p>a. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports (LTSS) are authorized in a manner that</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Utilization management plan</li> <li>Member materials, such as the member handbook</li> <li>Coverage guidelines/criteria</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>3 and 3a: Healthy Blue Member Handbook pg 88</li> <li>3b: Healthy Blue Member Handbook: pg 31</li> <li>3, 3a, 3b: Utilization Management-LA Policy, pg 32</li> <li>UM Program Description, pg 18</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>reflects the member’s ongoing need for such services and supports.</p> <p>b. Family planning services are provided in a manner that protects and enables the member’s freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.</p> <p style="text-align: right;">42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10</p>	<ul style="list-style-type: none"> <li>Healthy Blue Member Handbook, pg 28-41 (Coverage guidelines/criteria)</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s Utilization Management-LA Policy, UM Program Description, and Healthy Blue Member Handbook demonstrate the processes in place for service limits based on criteria, medical necessity, and other utilization controls.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>4. The MCE specifies what constitutes “medically necessary services” in a manner that:</p> <p>a. Is no more restrictive than that used by the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and</p> <p>b. Addresses the extent to which the MCE is responsible for covering services that address:</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>4a: Healthy Blue Member Handbook pg 27</li> <li>4b: Healthy Blue Member Handbook pg 27</li> <li>4: Utilization Management-LA Policy, pg 6</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>i. The prevention, diagnosis, and treatment of a member’s disease, condition, and/or disorder that results in health impairments and/or disability.</p> <p>ii. The ability for a member to achieve age-appropriate growth and development.</p> <p>iii. The ability for a member to attain, maintain, or regain functional capacity.</p> <p style="text-align: right;">42 CFR §438.210(a)(5)</p> <p>MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11</p>	<ul style="list-style-type: none"> <li>4a: Utilization Management-LA Policy, pg 32</li> <li>4b, 4bi: Utilization Management-LA Policy pg32</li> <li>4bii, 4biii: Utilization Management-LA Policy pg 33</li> <li>4a: Health Care Management Denial-LA Policy, pg 20</li> <li>4bi-biii: Health Care Management Denial-LA Policy, pg 19</li> <li>UM Program Description, pg 16</li> <li>Healthy Blue Provider manual, pg 28</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s Utilization Management-LA Policy, UM Program Description, and Healthy Blue Provider Handbook, and Healthy Blue Member Handbook specifies medically necessary services.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Authorization of Services		
<p>5. The MCE and its subcontractors have in place, and follow, written policies and procedures for the processing of requests for initial and continuing authorization of services.</p> <p style="text-align: right;">42 CFR §438.210(b)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Coverage guidelines/criteria</li> <li>List of delegated entities performing utilization management</li> <li>Delegated written contract (for entities responsible for delegated UM functions)</li> <li>Delegation oversight of policies and procedures (e.g., audit results)</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Utilization Management-LA Policy, pg 8</li> <li>• Utilization Management-LA Policy, pg 8 (subcontractor)</li> <li>• Healthy Blue Member Handbook, pg 28-41 (Coverage guidelines/criteria)</li> <li>• UM Program Description, pg 45</li> <li>• Utilization Management-Medicaid Delegation and Oversight-LA Policy, pg 1</li> <li>• Utilization Management-Medicaid Delegation and Oversight Policy, pg 1</li> <li>• List of Delegated Entities</li> <li>• Delegate-Vendor Oversight and Management Program Policy, pg 3 and 5</li> <li>• Carelon Behavioral Health fka Beacon Health Contract</li> <li>• DentaQuest Contract-Zip File</li> <li>• Carelon MBM Contract-Zip File</li> <li>• Prime Therapeutics fka Magellan Health Contract-zip file</li> <li>• DentaQuest AA 2024 UM-Audit</li> <li>• Carelon MBM 2024 UM-Audit</li> <li>• Carelon BH AA 2024 UM-Audit</li> <li>• Prime Therapeutics UM AA 2024-Audit</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 2024 Utilization Management-Medicaid Delegation and Oversight, Pg 5-8</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Healthy Blue ensures its delegates and subcontractors comply with all contractual aspects as evidenced by policies, workflows, contracts, and audits.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Coverage guidelines/criteria</li> <li>Results of inter-rater reliability (IRR) activities</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>6 Utilization Management-LA Policy, pg 17</li> <li>6 UM Program Description, pg 37</li> <li>6 2024 UM Program Evaluation, pgs 15-19</li> <li>6 Healthy Blue Member Handbook, pg 28-41 (Coverage guidelines/criteria)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 UM Program Evaluation (HBL), Pg 15, 16, 17, 18,19</li> <li>2024 Carelon BH IRR Results</li> <li>Inter-Rater Reliability IRR Policy, Pg 1,2, and 3</li> <li>Utilization Management-LA Policy, Pg 17 and 51</li> <li>2024 HBL PIE Audit Scores</li> <li>2024 Carelon BH PIE Audit Scores</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Carelon BH associates are audited monthly by PIE Audit Team and results are shared with managers. Carelon BH PIE Audit Scores are shared quarterly in the Healthy Blue Clinical Services Committee meetings.</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue has a formal auditing method performed annually to assess IRR of non-physician and physician associated in applying medical necessity criteria to ensure consistency and accuracy in the application of criteria. This process is outlined in the Utilization Management-LA Policy, UM Program Description, and 2024 UM Program Evaluation.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>7. The MCE consults with the requesting provider for medical services when appropriate.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Provider materials, such as the provider manual, provider communications</li> <li>Three case examples of peer-to-peer consults</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>7 Utilization Management-LA Policy, pg 10</li> <li>7 UM Program Description, pg 19</li> <li>7 Healthy Blue Provider Manual, pg 135</li> <li>7 Peer-to-Peer Examples</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue consults with the requesting provider regarding medical services when appropriate and the process is demonstrated in the Utilization Management-LA Policy, UM Program Description, Healthy Blue Provider Manual, and 3 Peer-to-Peer Examples</p>		
<p><b>HSAG Findings:</b> HSAG has scored this element as not applicable since State requirements differ from federal requirements. While the contract allowed for an “informal reconsideration” process in which a denial is overturned following a peer-to-peer discussion, CMS has articulated that</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>the MCEs’ practice of adjusting prior authorization denial decisions based on peer-to-peer discussions occurring after the MCE sends a member a notice of ABD is inconsistent with Medicaid managed care regulations and, rather, is consistent with CMS’ definition of an appeal. HSAG has communicated this information to LDH.</p>		
<p><b>Required Actions:</b> The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.</p>		
<p>8. The MCE authorizes LTSS based on a member’s current needs assessment and consistent with the person-centered service plan.</p> <p style="text-align: right;">42 CFR §438.210(b)(2)(iii)</p> <p>MCO Contract: NA PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Authorization workflow for LTSS</li> <li>• UM program description</li> <li>• Coverage guidelines/criteria</li> <li>• Three examples of authorized LTSS and copies of the corresponding person-centered service plans</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• N/A</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> N/A: Healthy Blue is not in scope for LTSS.</p>		
<p><b>HSAG Findings:</b> Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>9. The MCE ensures 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, be made by an individual who has appropriate expertise in addressing the member’s medical, behavioral health.</p> <p>MCO:</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• UM program description</li> <li>• Job descriptions for UM decision makers</li> <li>• HSAG will also use the results of the Service Authorization Denial File Review</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>a. <i>The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of an Enrollee's condition or disease and training in the use of any required assessments shall determine Service Authorization request denials or authorize a service in an amount, duration or scope that is less than requested.</i></p> <p>PAHP:</p> <p>a. <i>Made by a licensed dentist, as appropriate, or other professional as approved by LDH, who has appropriate clinical experience in treating the enrollee's condition.</i></p> <p style="text-align: right;">42 CFR §438.210(b)(3) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>9 Utilization Management-LA Policy, pg 49</li> <li>9 Medical Director, Mgr Medical Director, Plan Performance Medical Director, and Psychologist Reviw Job Description</li> <li>9: Health Care Management Denial-LA Policy, pg 6</li> <li>9a: Health Care Management Denial-LA Policy, pg 7</li> <li>UM Program Description, pg 13</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>PIE Audit Tool</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue's Utilization Management-LA Policy, UM Program Description, and Job Descriptions demonstrate processes in place to ensure only individuals with appropriate expertise are issuing adverse actions for service requests.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p><b>Notice of Adverse Benefit Determination</b></p>		
<p>10. The MCE notifies the requesting provider of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Provider notice template</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>MCO:</p> <p>a. <i>The MCO shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.</i></p> <p>PIHP:</p> <p>a. <i>The notification shall include an explanation describing the reason(s) for authorization of a service in an amount, duration, or scope that is less than requested. The PIHP shall notify the provider rendering the service, verbally 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 written confirmation of such notification to the provider within two (2) business days of making the initial determination.</i></p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2</p>	<ul style="list-style-type: none"> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Utilization Management-LA Policy, pg 20</li> <li>Health Care Management Denial-LA Policy, pg 13</li> <li>UM Program Description, pg 26</li> <li>Denial Template Provider Notice Example</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s process of notifying a requesting provider of an adverse determination are outlined in the Utilization Management-LA Policy, UM Program Description, and Health Care Management Denial-LA Policy, along with examples.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. The MCE defines an adverse benefit determination (ABD) as:</p> <p>a. The denial or limited authorization of a requested service, including determinations based on the type or</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.</p> <p>b. The reduction, suspension, or termination of a previously authorized service.</p> <p>c. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” is not an ABD.</p> <p>d. The failure to provide services in a timely manner, as defined by the State.</p> <p>e. The failure of the MCE to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.</p> <p>f. For a resident of a rural area with only one MCE, the denial of a member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network.</p> <p>g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.</p> <p style="text-align: right;">42 CFR §438.52(b)(2)(ii) 42 CFR §438.400(b)(1-7) 42 CFR §438.408(b)(1-2) 42 CFR §457.1260(a)(2)</p> <p>MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 11a-g: Health Care Management Denial-LA Policy, pg 3</li> <li>• 11-11e, 11g: Utilization Management-LA Policy, pg 4</li> </ul>	



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b> Healthy Blue defines ABD in the Utilization Management-LA Policy and the Health Care Management Denial-LA Policy.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>12. The MCE gives members written notice of any decision by the MCE to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The ABD notice includes the following:</p> <ol style="list-style-type: none"> <li>a. The ABD the MCE has made or intends to make.</li> <li>b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.</li> <li>c. The member’s right to request an appeal of the MCE’s ABD, including information on exhausting the MCE’s one level of appeal, described at 42 CFR §438.402(b), and right to request a State fair hearing consistent with 42 CFR §438.402(c).</li> <li>d. The procedures for exercising the rights specified in 42 CFR §438.402(b).</li> <li>e. The circumstances under which an appeal process can be expedited and how to request it.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• UM program description</li> <li>• ABD notice template with taglines</li> <li>• HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 12, 12a: Health Care Management Denial-LA Policy, pg 15</li> <li>• 12b: Health Care Management Denial-LA Policy, pg 15</li> <li>• 12c, 12d: Health Care Management Denial-LA Policy, pg 15, 16</li> <li>• 12e: Health Care Management Denial-LA Policy, pg 16</li> <li>• 12f: Health Care Management Denial-LA Policy, pg 16</li> <li>• 12g: Health Care Management Denial-LA Policy, pg 16</li> <li>• 12, 12a:UM Program Description, pg 26</li> <li>• 12b: UM Program Description, pg 26</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>f. The member’s right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with State policy, under which the member may be required to pay the costs of these services.</p> <p>g. The notice must be consistent with the requirements of 42 CFR §438.10.</p> <p style="text-align: center;">42 CFR §438.10 42 CFR §438.210(c) 42 CFR §438.402(b-c) 42 CFR §438.404(a-b) 42 CFR §457.1230(d) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(c)(1-2)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2</p>	<ul style="list-style-type: none"> <li>• 12c: UM Program Description, pg 26</li> <li>• 12d: UM Program Description, pg 26</li> <li>• 12e: UM Program Description, pg 27</li> <li>• 12f: UM Program Description, pg 30</li> <li>• 12, 12a: Healthy Blue Provider Manual, pg 132</li> <li>• 12b: Healthy Blue Provider Manual, pg 132</li> <li>• 12c: Healthy Blue Provider Manual, pg 72</li> <li>• 12d: Healthy Blue Provider Manual, pg 73</li> <li>• 12e: Healthy Blue Provider Manual, pg 73</li> <li>• 12f: Healthy Blue Provider Manual, pg 74</li> <li>• 12g: Healthy Blue Provider Manual, pg 19</li> <li>• 12: Utilization Management-LA Policy, pg 20</li> <li>• Denial Notice Template with Taglines</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Denial Letter Team Desktop Process</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s member notification process is detailed and evidenced in the Health Care Management Denial-LA Policy, Utilization Management-LA Policy, UM Program Description, Healthy Blue Provider Manual, as well as the Denial Template Notice with taglines.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Recommendations:</b> HSAG recommends that the MCE add functionality to the system that houses and tracks prior authorization requests and resolutions so that users may document that notices of adverse benefit determination (ABD) include all requirements and indicate that the reading grade level has been verified.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>Timeframe for Decisions</b>		
<p>13. For standard authorization decisions, the MCE provides notice as expeditiously as the member’s condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• UM program description</li> <li>• Tracking and reporting mechanisms</li> <li>• Service authorization log(s) within the time period under review</li> <li>• HSAG will also use the data from the universe file</li> <li>• HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Utilization Management-LA Policy, pg 19</li> <li>• Health Care Management Denial-LA Policy, pg 17</li> <li>• UM Program Description, pg 22</li> <li>• 2024 Q1, Q2, Q3, Q4 NBH and BH 188 Reports</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue’s standard authorization decision process is described in the Utilization Management-LA Policy, Health Care Management Denial-LA Policy, UM Program Description, and resulted in the 2024 NBH/BH 188 Quarterly Reports.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>14. For cases in which a provider indicates, or the MCE determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• UM program description</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>to attain, maintain, or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later 72 hours after receipt of the request for service.</p> <p style="text-align: right;">42 CFR §438.210(d)(2)(i) 42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8</p>	<ul style="list-style-type: none"> <li>Tracking and reporting mechanisms</li> <li>Service authorization log(s) within the time period under review</li> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>14: Utilization Management-LA Policy, pg 19</li> <li>Health Care Management Denial-LA Policy, pg 12</li> <li>UM Program Description, pg 22</li> <li>2024 Q1, Q2, Q3, Q4 NBH and BH 188 Reports</li> </ul>	<input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue’s expedited authorization decision process is described in the Utilization Management-LA Policy, Health Care Management Denial-LA Policy, UM Program Description, and resulted in the 2024 NBH/BH 188 Quarterly Reports.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if:</p> <ol style="list-style-type: none"> <li>The member, or the provider, requests the extension; or</li> <li>The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member’s interest.</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Tracking and reporting mechanisms</li> <li>Extension notice template</li> <li>Three case examples of authorizations with an extension, including the date of receipt of the</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>42 CFR §438.210(d)(1)(i-ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3)</p> <p>MCO Contract: 2.12.6.1.3 PAHP Contract: 2.5.7.2.4 PIHP Contract: 11.3.3.1.5; 11.3.3.1.9</p>	<p>authorization request and date of the decision to extend the time frame</p> <ul style="list-style-type: none"> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Utilization Management-LA Policy, pg 19</li> <li>15, 15a, 15b: Health Care Management Denial-LA Policy, pg 12</li> <li>UM Program Description, pg 23</li> <li>Extension Notice Template, pg 1</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Extension Notice Attestation</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s expedited authorization decision process is described in the Utilization Management-LA Policy, Health Care Management Denial-LA Policy, and UM Program Description. A review of our database was performed for examples from January 1, 2024 to December 31, 2024. We were not able to locate any examples of notices sent where an extension notice was sent. Our policy does comply and if resolution extension is required Healthy Blue would notify members and providers timely.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>16. If the MCE meets the criteria set forth for extending the timeframe for standard and expedited service authorization decisions consistent with 42 CFR §438.210(d)(1)(ii) and 42 CFR §438.210(d)(2)(ii), it:</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Tracking and reporting mechanisms</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>a. Gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision; and</p> <p>b. Issues and carries out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.</p> <p style="margin-left: 40px;">42 CFR §438.210(d)(1)(ii) 42 CFR §438.210(d)(2)(ii) 42 CFR §438.404(c)(4)(i-ii) 42 CFR §457.1230(d)</p> <p>MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6</p>	<ul style="list-style-type: none"> <li>Extension notice template(s)</li> <li>Three case examples of authorizations with an extension, including the written notice of the extension</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Health Care Management Denial-LA Policy, pg 18</li> <li>UM Program Description, pg 24</li> <li>Extension Notice Template, pg 1</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s process for extending timeframes for standard and expedited service requests is described in the, Health Care Management Denial-LA Policy and UM Program Description. A review of our database was performed for examples from January 1, 2024 to December 31, 2024. We were not able to locate any examples of notices sent; however we have the Extension Notice Template available if needed. Our policy does comply and if timeframe extension is required Healthy Blue would notify members and providers timely.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA).</p> <p>a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.</p> <p style="margin-left: 40px;">42 CFR §438.210(d)(3) 42 CFR §457.1230(d)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Three examples of notice</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>UM Program Description, pg 45</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p style="text-align: right; margin-right: 20px;">SSA §1927(d)(5)(A)</p> <p>MCO Contract: None PAHP Contract: NA PIHP Contract: None</p>	<p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>055_Pharm Report_2410_HBL</li> <li>HBL Q42024 JOC</li> <li>LA Q3 MAC July 2024</li> <li>LA Q4 2024 CSC Pharmacy</li> </ul>	
<p><b>MCE Description of Process:</b> Not applicable as the MCE had a single PBM.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>18. For termination, suspension, or reduction of previously authorized Medicaid-covered services, the MCE mails the ABD notice to the member within at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and §431.214.</p> <p style="text-align: right; margin-right: 20px;">           42 CFR §431.211            42 CFR §431.213            42 CFR §431.214            42 CFR §438.210(c)            42 CFR §438.404(c)(1)            42 CFR §457.1230(d)         </p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>Advance ABD notice template(s)</li> <li>Tracking and reporting mechanisms</li> <li>Three case examples of advance notices, including the ABD notice and the effective date of decision</li> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the service authorization denial file review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Health Care Management Denial-LA Policy, pg 17</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>2024 DTP Member Transition and Notification for TSR</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s Health Care Management Denial-LA Policy does include the requirement language. Healthy Blue’s adverse action notification process is dependent upon the received date of the request and having appropriate documentation to render a decision as outlined in the Contract citation, specifically in regards to providing written notification within 2 business days. Healthy Blue also considers Contract citation 2.12.6.3.2 where we do “not subsequently retract an authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous authorization approval...” A review of our database was performed for examples from January 1, 2024 to December 31, 2024. We were not able to locate any examples where an Advanced ABD notice was sent.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>19. The MCE may send a notice not later than the date of action if:</p> <ol style="list-style-type: none"> <li>a. The MCE has factual information confirming the death of a member;</li> <li>b. The MCE receives a clear written statement signed by a member that:               <ol style="list-style-type: none"> <li>i. The member no longer wishes services; or</li> <li>ii. Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;</li> </ol> </li> <li>c. The member has been admitted to an institution where the member is ineligible under the plan for further services;</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>ABD notice template(s)</li> <li>Tracking and reporting mechanism(s)</li> <li>Three examples of an ABD notice sent to a member that meets one of the criteria of this element (one example must apply to a deceased member, one example must apply to a member who no longer wishes to receive services, and one example must apply to a member who is no longer eligible for services through the MHP)</li> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>d. The member’s whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address;</p> <p>e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;</p> <p>f. A change in the level of medical care is prescribed by the member’s physician;</p> <p>g. The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Social Security Act; or</p> <p>h. The date of action will occur in less than 10 days, in accordance with §483.15(b)(4)(ii) and (b)(8), which provides exceptions to the 30 days notice requirements of §483.15(b)(4)(i).</p> <p style="text-align: right;">42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>19a-19f: Health Care Management Denial-LA Policy, pg 17</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 DTP Member Transition and Notification for TSR</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue’s Health Care Management Denial-LA Policy does include the requirement language. Healthy Blue’s adverse action notification process is dependent upon the received date of the service request as outlined in the Contract citation, specifically in regard to providing written notification within 2 business days. A review of our database was performed for examples from January 1, 2024 to December 31, 2024. We were not able to locate any examples where notice was sent for the reasons outlined in this section.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>20. The MCE may shorten the period of advance notice to five days before the date of action if:</p> <p style="margin-left: 20px;">a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and</p> <p style="margin-left: 20px;">b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>ABD notice template(s)</li> <li>Tracking and reporting mechanism(s)</li> <li>Three examples of an ABD notice sent to a member due to probable fraud</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>20, 20a, 20b: Health Care Management Denial-LA Policy, pg 17</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 DTP Member Transition and Notification for TSR</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<b>MCE Description of Process:</b> Healthy Blue’s Health Care Management Denial-LA Policy does include the requirement language. Healthy Blue’s adverse action notification process is dependent upon the received date of the service request as outlined in the Contract citation, specifically in regard to providing written notification within 2 business days. A review of our database was performed for examples from January 1, 2024 to December 31, 2024. No notices sent in 2024 for probable fraud for ABD in 2024.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim.</p> <p style="text-align: right;">42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Workflow/guidelines for payment denial on a claim to trigger ABD notice</li> <li>UM program description</li> <li>ABD notice template for denial of payment</li> <li>Tracking and reporting mechanism(s)</li> <li>Three case examples of the denial of payment on a claim, including date of the denial and ABD notice</li> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Health Care Management Denial-LA Policy, pg 17</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 DTP Member Transition and Notification for TSR</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The Health Care Management Denial Policy outlines when the Notice of action is mailed.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>22. For standard and expedited service authorization decisions not reached within the required timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an ABD), the MCE provides notice on the date that the timeframes expire.</p> <p style="text-align: right;">42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>ABD notice template for untimely determination</li> <li>Service authorization log(s) within the time period under review</li> <li>Tracking and reporting mechanism(s)</li> <li>Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice</li> <li>HSAG will also use the data from the universe file</li> <li>HSAG will also use the results of the Service Authorization Denial File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Health Care Management Denial-LA Policy, pg 18</li> <li>UM Program Description, pg 24</li> <li>Untimely Decision Template</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 DTP Member Transition and Notification for TSR</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue’s Health Care Management Denial-LA Policy does include the requirement language. A review of our database was performed for examples from January 1, 2024 to December 31, 2024. We were not able to locate any examples where notice was sent for expired timeframes for standard or expedited service authorization decisions; however, Healthy Blue does have a ABD notice template for untimely determinations available if needed.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Compensation for Utilization Management Activities		
<p>23. The MCE provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d)</p> <p>MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>New hire and ongoing training for staff</li> <li>Three examples of staff attestations</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>23 Annual and Ongoing Ethics, Compliance and Privacy Training All</li> <li>23 New Associate Ethics, Compliance and Privacy Training</li> <li>Healthy Blue Member Handbook, pg 27</li> <li>Utilization Management-LA Policy, pg 49</li> <li>Health Care Management Denial-LA Policy, pg 2</li> <li>UM Program Description, pg 13</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Healthy Blue ensures individuals conducting utilization management activities are not structured or incentivized to deny, limit, or discontinue medically necessary services it’s members. The process is identified and described in the Healthy Blue Member Handbook, the Utilization Management-LA Policy, and the UM Program Description. Yearly compliance training is completed by associates performing utilization management. The new hire and ongoing training policies are designed to deliver new and continuous education to associates on current ethics and compliance issues that are applicable to Elevance Health business.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Results for Standard VII—Coverage and Authorization of Services						
<b>Total</b>	Met	=	21	X	1	= 21
	Not Met	=	0	X	0	= 0
	Not Applicable	=	2			
<b>Total Applicable</b>		=	21	<b>Total Score</b>	=	21

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<b>General Rules</b>		
<p>1. The MCE implements written policies and procedures for selection and retention of network providers and those policies and procedures, at a minimum, meet the requirements of 42 CFR §438.214.</p> <p>MCO: For the MCOs, additional requirements must be followed according to 2.9.30.1, 2.9.30.3 in the MCO Contract, and in the MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff.</p> <p style="text-align: right;">42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.29.3; 2.9.30.1; 2.9.9.4; 2.9.30.3; MCO Manual, Credentialing and Re-credentialing of Providers and Clinical Staff PAHP Contract: 2.6.9.11 PIHP Contract: 6.8.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1. Policy 1 Credentialing Program Structure, Page 3, Sections ii. and iii.; Page 4, Section IV.</li> <li>• 1. Policy 2 Credentialing Program Provider Scope, Pages 1-7.</li> <li>• 1. Policy 3 Geographic Credentialing Committee, Page 1, Section 2i-ii</li> <li>• 1. Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, Section 2.A., Pages 3-19, Section 5</li> <li>• 1. Policy 4.0.1 BH – Education Criteria, Page 1, Section 2; Pages 3-9, Section 5</li> <li>• 1. Policy 4.0.2 Cred NP, CNM and PA, Page 1, Section 2; Pages 3-10, Section 5</li> <li>• 1. Policy 4.1 Professional Competence and Conduct Criteria – Health Delivery Organizations (HDOs), Page 1, Section 2; Pages 3-9, Section 5</li> <li>• 1. Policy 5 Initial Application, Page 1, Section 2; Pages 2-10, Section 5.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>1. Policy 6 Process for Verification of Data Elements Page 1, Section 2; Pages 2-6, Section 5; Pages 6-11, Attachment A and Attachment B.</li> <li>1. Policy 9 Re-credentialing, Page 1, Section 2; Pages 2-13, Section 5.</li> <li>1. Policy 10 Termination and Immediate Termination, Pages 1-2, Section 2; Pages 5-6, Section 5.</li> <li>1. Additional State Specific Regulatory or Contractual Requirements for Louisiana, Entire Policy</li> <li>1. Credentialing Systems Control Policy, Page 1, Section 1.</li> </ul>	
<p><b>MCE Description of Process:</b> Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recredentialing of providers and how credentialing information is received, stored, reviewed, tracked and dated. These established policies and procedures help to ensure quality of care. The credentialing process utilizes the Uniform Credentialing/Recredentialing Provider Application through the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source to capture all required data and is compliant with National Committee for Quality Assurance (NCQA) and consistent with Louisiana Department of Health contract requirements. The LA Credentials Committee is supported by the Credentialing department, which conducts all verifications and credential file preparation.</p> <p>Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. Site visits are conducted for any facility that is not accredited or does not have a Medicare survey or that is not identified on the Health Resources and Services Administration shortage designation list.</p> <p>Credentialing policies and procedures comply with NCQA, state, and federal laws and regulations, including 42 CFR 438.214 and 42 CFR 1002.3.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>2. The MCE follows a documented process for credentialing and recredentialing of network providers that meets the State requirements for each of the following provider types:</p> <ul style="list-style-type: none"> <li>a. Acute;</li> <li>b. Primary;</li> <li>c. Mental health;</li> <li>d. Substance use disorders.</li> </ul> <p style="text-align: right; margin-right: 50px;">42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.4; 2.9.30.1 PAHP Contract: 2.6.9.11.1 PIHP Contract: 6.7.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2. Policy 1 Credentialing Program Structure, Page 3, Sections ii. And iii.; Page 4, Section IV.</li> <li>• 2.a.b.c. Policy 2 Credentialing Program Provider Scope, Pages 1-7.</li> <li>• 2. Policy 3 Geographic Credentialing Committee, Page 1, Section 2i-ii; Page 5-8</li> <li>• 2. Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 1, Section 2.A., Pages 3, Section 5.</li> <li>• 2. Policy 4.0.1 BH – Education Criteria, Page 1, Section 2; Pages 3-9, Section 5</li> <li>• 2. Policy 4.0.2 Cred NP, CNM and PA, Page 1, Section 2; Pages 3-10, Section 5</li> <li>• 2. Policy 4.1 Professional Competence and Conduct Criteria – Health Delivery Organizations (HDOs), Page 1, Section 2; Pages 3-9, Section 5</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>2. Policy 5 Initial Application, Page 1, Section 2; Pages 2-10, Section 5</li> <li>2. Policy 6 Process for Verification of Data Elements Page 1, Section 2; Pages 2-6, Section 5; Pages 6-11, Attachment A and Attachment B.</li> <li>2. Policy 9 Re-credentialing, Page 1, Section 2; Pages 2-13, Section 5</li> <li>2. Policy 10 Termination and Immediate Termination, Pages 1-2, Section 2; Pages 5-6, Section 5</li> <li>2.a.b.c.d. Additional State Specific Regulatory or Contractual Requirements for Louisiana, Entire Policy</li> </ul>	
<p><b>MCE Description of Process:</b> Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recredentialing of providers and how credentialing information is received, stored, reviewed, tracked and dated. These established policies and procedures help to ensure quality of care. The credentialing process utilizes the Uniform Credentialing/Rec credentialing Provider Application through the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source to capture all required data and is compliant with National Committee for Quality Assurance (NCQA) and consistent with Louisiana Department of Health and contract requirements. The LA Credentials Committee is supported by the Credentialing department, which conducts all verifications and credential file preparation.</p> <p>The Additional State Specific Regulatory or Contractual Requirements for Louisiana policy identifies any state specific or contractual requirements for a particular state as it relates to the credentialing and recredentialing processes. This policy is designed to be used in conjunction with the core Credentialing policies. State specific regulatory and contractual requirements take precedent over the requirements of the core credentialing policies for those lines of businesses affected by the state specific regulatory or contractual requirements.</p> <p>Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p> <p>The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. Site visits are conducted for any facility that is not accredited or does not have a Medicare survey or that is not identified on the Health Resources and Services Administration shortage designation list.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Nondiscrimination		
<p>3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Nondiscrimination statement for credentialing committee members</li> <li>Mechanism for monitoring for discriminatory practices</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>3. Policy 5 Initial Application, Page 9-10</li> <li>3. March 2025 LA Credentials Committee Minutes-Approval- Page 6</li> <li>3. 2024 Non-Discrimination Report</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> In compliance with 42 CFR 438.214(c), discrimination is not allowed against any potential provider on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein. The credentialing process does not discriminate against (1) a health care professional solely on the basis of license or certification; or (2) a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions. This information is not required or collected in the credentialing or recredentialing process.</p>		



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Requirement	Supporting Documentation	Score
<p>The Credentials Committee bases their decision on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process. The Company will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>4. The MCE may not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.</p> <p style="margin-left: 20px;">a. If the MCE declines to include individual or groups of providers in its provider network, it must give the affected providers written notice of the reason for its decision.</p> <p style="margin-left: 20px;">b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.9.7.8; 2.9.9.1; 2.9.9.2 PAHP Contract: 2.6.8.1; 2.6.9.10; 2.6.10.1 PIHP Contract: 6.1.12.3; 6.1.16.2; 6.1.17</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider notice template(s) for adverse credentialing and/or contracting decisions</li> <li>Examples of one individual and one organizational executed provider contracts</li> <li>Nondiscrimination statement for credentialing committee members</li> <li>Mechanism for monitoring for discriminatory practices</li> <li>HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>4. Policy 5 Initial Application, Pages 9-10</li> <li>4.a. BLAPEC-1468_Denial Letter Template</li> <li>4. March 2025 LA Credentials Committee Minutes-Approval- Page 6</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>4. 2024 Non-Discrimination Report</li> <li>4b. Blank Louisiana Medicaid Contract</li> <li>4. BLAPEC-0603-17_ Provider Termination Without Cause Letter Template</li> <li>4b. HDO Contract Example. Physicians Behavioral Hospital_ Healthy Blue LA Standard Agreement .pdf</li> <li>4b. Provider Contract Example. LeAndre William Odom_ Healthy Blue LA Standard Agreement</li> <li>4a. Decline Network email</li> <li>4.b _Contract Example _Facility.pdf (Pg. 5)</li> <li>Standard VIII.4.b _Contract Example _Professional Group (Pg. 6)</li> <li>Standard VIII.4.b _Healthy Blue Provider Manual_ 2023.pdf (Pg. 142)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Standard VIII.4. _Healthy Blue Provider Manual_ 2023, section 2.24, page 29.pdf</li> <li>Section 2.24. Provider Bill of Rights on page 29, bullet point 7 states: Be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> In compliance with 42 CFR 438.214(c), discrimination is not allowed against any potential provider on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran status, marital status, or any unlawful basis not specifically mentioned herein. The credentialing process does not discriminate against (1) a health care professional solely on the basis of license or certification; or (2) a health care professional who serves high-risk populations or who specializes in the treatment of costly conditions. This information is not required or collected in the credentialing or recredentialing process.</p> <p>The Credentials Committee bases their decision on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process.</p> <p>“Standard VIII.4.b_Contract Example_Facility.pdf (Pg. 5)” &amp; “Standard VIII.4.b_Contract Example_Professional Group (Pg. 6)” provide examples of Healthy Blue’s provider contracts. While the contracts themselves do not specifically outline the health plan’s nondiscrimination policy as it pertains to the credentialing of providers, the contracts’ section on Provider Credentialing refers providers to the Healthy Blue Provider Manual for specifics on credentialing. The Provider Manual, as presented in “Standard VIII.4.b_Healthy Blue Provider Manual_2023.pdf (Pg. 142),” provides clarification to contracted providers of the health plan’s commitment to nondiscriminatory credentialing practices in compliance with 42 CFR 438.214(c).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Excluded Providers		
<p>5. The MCE may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3</p> <p>MCO Contract: 2.9.8.1; 6.5.6; 2.2.2.1.4 PAHP Contract: 2.6.3.3.1; 2.6.3.3.2; 6.7.3.1 PIHP Contract: 6.8.8; 13.4.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included)</li> <li>Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included)</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity</li> <li>HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review</li> </ul>	
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>5. Policy 2 Credentialing Program Provider Scope, Pages 1, 4, and 6</li> <li>5. Policy 4 Professional Competence and Conduct Criteria – Practitioners, Page 3</li> <li>5. Policy 4.0.2 Cred NP, CNM and PA, Pages 5, 7, and 9</li> <li>5. Policy 4.1 Professional Competence and Conduct Criteria – Health Delivery Organizations (HDOs), Page 4</li> <li>5. Policy 12 Ongoing Sanction Monitoring – Pages 1, 2, and 3</li> <li>5. LA Federal Sanctions</li> <li>5. LA State Board Sanctions</li> <li>5. LA Tracking Log January 2024 to December 2024</li> <li>5. LA-CR2-Sanctions-DARS Ongoing Monitoring_01012024-12312024</li> <li>5. LA-CR2-Sanctions-OIG Exclusions Ongoing Monitoring_01012024-12312024</li> <li>5. Delegated Cred Agreement (DCA) Template Pages 12-14 and 31-32</li> <li>5. Verity HealthNet DCA Pages 12-14 and 31</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> A practitioner’s or HDO’s participation in the Company’s programs or provider network(s) may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence credentialing criteria, involving licensure (revocation, suspension or surrender), required medical staff membership, privileges, certification, accreditation, or sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs.</p> <p>Credentialing associates perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listing/reports within 30 days of the time they are made available from the various sources including, but not limited to, the following:</p> <ul style="list-style-type: none"> <li>Office of the Inspector General</li> <li>Federal Medicare/Medicaid Reports</li> <li>Office of Personnel Management</li> <li>State licensing Boards/Agencies</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
State Requirements		
<p>6. The MCE complies with any additional requirements established by the State.</p> <p>MCO:</p> <p>i. <i>The MCO, through its Compliance Officer, shall attest monthly to LDH that it has screened all providers as specified in the debarment/suspension/exclusion section or that it has verified and confirmed that the provider is enrolled with the State.</i></p> <p>ii. <i>The Contractor shall report to LDH, within three (3) Business Days, when it has discovered that any Contractor employee(s), Network Provider, Subcontractor, or Subcontractor's employee(s) have</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Three consecutive months of attestations submitted to LDH</li> <li>HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>6.c.Policy 6 Process for Verification of Data Elements, pages 3-6, and 11</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>been excluded, suspended, or debarred from any State or Federal health care benefit program via the designated LDH Program Integrity contact.</i></p> <p>iii. <i>The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program 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 Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]</i></p> <p><b>PIHP:</b></p> <p>a. <i>An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.</i></p> <p>b. <i>The Contractor shall notify LDH within three (3) business days of the time it receives notice that action is being taken against the Contractor 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) which could result in exclusion, debarment, or suspension of the Contractor from the Medicaid or</i></p>	<ul style="list-style-type: none"> <li>6.b.c. BLAPEC-0603-17 _ Provider Termination Without Cause Letter Template.pdf</li> <li>6.b.c. Terminations Report JAN.FEB. MARCH</li> <li>6.a-c Medicaid Program Integrity Attestation October</li> <li>6.a-c Medicaid Program Integrity Attestation November</li> <li>6.a-c Medicaid Program Integrity Attestation December</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>The Contract Compliance Officer is aware of all monthly checks and attestations prior to the attestation signature.</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><i>CHIP program, or any program listed in Executive Order 12549.</i></p> <p style="text-align: right;">42 CFR §438.214(e) 42 CFR §457.1233(a)</p> <p>MCO Contract: 2.20.3.7; 2.20.3.11; 2.20.5.3 PAHP Contract: None PIHP Contract: 13.2.2; 13.2.4</p>		
<p><b>MCE Description of Process:</b> Report termination notification outlier data associated with physical and behavioral health providers, with the expectation that barriers or issues negatively impacting compliance with R.S. 46:460.72 (Act 489) are documented and addressed. Provider initiated terminations should also be reported on this tab. Terminations issued because of failure to comply with the re-credentialing process should not be included.</p> <p>Medicaid Program Integrity Attestation</p> <p>This document attests that, over the past three months, the required monthly screenings of providers, employees, and subcontractors have been completed in compliance with Contract Sections 2.20.3 and 6.17, as well as 42 CFR § 455.436.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Practitioner Verification of Credentials		
<p>7. For credentialing and recredentialing, the MCE primary source verifies that the practitioner has a current and valid license to practice in all states where the practitioner provides care to members within 180 calendar days of the credentialing decision.</p> <p style="padding-left: 20px;">a. <i>The MCE verifies the license directly from the state licensing or certification agency (or its website).</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.7.3; 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3; 2.6.9.2 PIHP Contract: 6.5.6; 6.7.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>7.a. Policy 6 Process for Verification of Data Elements, Page 2-6</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Practitioner Verification of Credentials		
<p>8. For credentialing and recredentialing, the MCE primary source verifies that the practitioner’s Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate is valid and current in each state where the practitioner provides care to members at the time of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>This requirement does not apply to practitioners who are not qualified to write prescriptions.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>8.a. Policy 6 Process for Verification of Data Elements, page 4</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		



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Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No required action needed.		
<p>9. For credentialing, the MCE verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate prior to the credentialing decision:</p> <p style="margin-left: 20px;">a. <i>Board certification;</i>  b. <i>Residency; or</i>  c. <i>Graduation from medical or professional school.</i></p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5  PAHP Contract: 2.6.8.1; 2.6.8.3  PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>9.a.b.c Policy 6 Process for Verification of Data Elements, page 5, 7-11</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>10. For credentialing and recredentialing, the MCE verifies the practitioner’s board certification status, if applicable, within 180 calendar days of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>Verification of board certification does not apply to nurse practitioners (NPS) or other health care</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>professionals unless the MCO communicates board certification to members.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<ul style="list-style-type: none"> <li>10.a. Policy 6 Process for Verification of Data Elements, page 4-6</li> </ul>	
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. For credentialing, the MCE verifies the practitioner’s work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision.</p> <p>a. <i>If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.</i></p> <p>b. <i>If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing. The MCE documents a verbal clarification or includes the written notice in the practitioner’s credentialing file.</i></p> <p>c. <i>If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>11.a.b.c. Policy 6 Process for Verification of Data Elements, Attachment B, Page 11</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6		
<b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
12. For credentialing and recredentialing, the MCE verifies a history of professional liability claims (from the malpractice carrier or the National Practitioner Databank [NPDB]), that resulted in settlement or judgment paid on behalf of the practitioner within 180 calendar days of the credentialing decision.  <div style="text-align: right; margin-right: 100px;">42 CFR §438.214(e)</div> MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>12. Policy 6 Process for Verification of Data Elements, Page 10, #15</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
<b>Practitioner Sanction Information</b>		
<p>13. For credentialing and recredentialing, the MCE verifies the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision.</p> <p style="margin-left: 20px;">a. <i>The MCE verifies State sanctions, restrictions on licensure and limitations on scope of practice in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</i></p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>13.a. Policy 6 Process for Verification of Data Elements, page 10-11, #16, 17&amp;18</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p>14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision.</p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 14. Policy 6 Process for Verification of Data Elements, page 10-11, #16, 17&amp;18</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Practitioner Credentialing Application/Attestation		
<p>15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include:</p> <ol style="list-style-type: none"> <li>a. <i>Reasons for inability to perform the essential functions of the position;</i></li> <li>b. <i>Lack of present illegal drug use;</i></li> <li>c. <i>History of loss of license and felony convictions;</i></li> <li>d. <i>History of loss or limitation of privileges or disciplinary actions;</i></li> <li>e. <i>Current malpractice insurance coverage; and</i></li> <li>f. <i>Current and signed attestation confirming the correctness and completeness of the application.</i></li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 15.a.b.c.d.e.f. Policy 5 Initial Application, page 6</li> <li>• 15.a.b.c.d.e.f. Policy 9 Re-credentialing, page 6</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



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Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p style="text-align: right; margin: 0;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6</p>		
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Practitioner Monitoring		
<p>16. The MCE develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identified occurrences of poor quality. The MCE develops and implements ongoing monitoring and makes appropriate interventions by:</p> <ol style="list-style-type: none"> <li>a. <i>Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);</i></li> <li>b. <i>Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and</i></li> <li>c. <i>Implementing appropriate interventions when it identifies instances of poor quality.</i></li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Provider complaints tracking reports</li> <li>• Provider adverse events tracking reports</li> <li>• Credentialing committee meeting minutes</li> <li>• Two examples of interventions taken based on poor quality of care</li> </ul>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA</p>
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 16. a.b.c.Policy 12 Ongoing Sanctions Monitoring, pages 5-6</li> <li>• 16.a.b. Provider Complaints Report_01012024_12312024</li> <li>• 16.a.b.QOC Report 2024</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	2 CFR §438.214(e) <ul style="list-style-type: none"> <li>16.c. Credentialing Committee Meeting Minutes Page 5 &amp; 6</li> </ul>	
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p> <p>For the QOC Report, any files with a severity of 3 or above should be discussed with the Credentialing Committee.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Organizational Verification of Credentials		
17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies.  MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	42 CFR §438.214(e)  <b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of organizational provider types and corresponding licensing body in the State of Louisiana</li> <li>HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review</li> </ul> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>17. Policy 6 Process for Verification of Data Elements</li> <li>17. LA Org License Grid</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
	<p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Policy 6 Process for Verification of Data Elements, Page 4-5, ii               <ul style="list-style-type: none"> <li>a. Practitioners – License to practice, (page 5) state and federal sanction checks.</li> <li>b. Health Delivery Organizations (HDOs) - (page 5) License to practice, state and federal sanction checks.</li> </ul> </li> </ul>	
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.</p> <p>a. <i>If the provider is not accredited, the MCE conducts an onsite quality assessment.</i></p> <p>i. <i>The MCE has a process for ensuring that the provider credentials their practitioners.</i></p> <p style="text-align: right;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 1.2.1.2.; 6.5.6; 6.7.4; 6.7.6; 6.7.8</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Onsite assessment review tool/template</li> <li>• HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 18.a.i. Policy 4.1 Professional Competence and Conduct Criteria -Health Delivery Organizations (HDOs), Page 7-8</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Primary Source Verification is conducted utilizing the information submitted by the provider in accordance with NCQA standards. The process will include verification of all required Louisiana Department of Health information. The credentialing policies and procedures guide the credentialing process. This includes assessment of the applicant’s training and education against training requirements established by the National Credentials Committee. The credentialing process will ensure that all providers are appropriately licensed or registered in accordance with the Louisiana Department of Health and any regulations thereunder or, if located in a jurisdiction outside of Louisiana in accordance with the health occupations regulatory requirements in the jurisdiction in which the provider practices.</p> <p>The credentialing requirements meet and exceed NCQA standards, providing an excellent framework to assess the clinical competence of each credentialed provider and ensure standards are applied consistently. Site visits are conducted for any facility that is not accredited or does not have a Medicare survey or that is not identified on the Health Resources and Services Administration shortage designation list.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation for one organizational recertification case file did not include evidence of accreditation or on-site quality assessment.</p>		
<p><b>Required Actions:</b> For credentialing and recertification, the MCE must verify the provider has been reviewed and approved by an accrediting body. If not accredited, the MCE must conduct an on-site quality assessment.</p>		
Time Frames		
<p>19. The MCE ensures that the credentialing process provides for mandatory recertification at a minimum of every 36 months in accordance with NCQA requirements.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.214(e)</p> <p>MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Recertification timeliness report during the review period</li> <li>HSAG will also use the results of the Practitioner and Organizational Credentialing and Recertification File Review</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>19. Policy 9 Re-credentialing, page 1</li> </ul>		
<p><b>MCE Description of Process:</b> Written credentialing policies and procedures describe the scope, criteria, timeliness, specific procedures for conducting credentialing and recertification of providers and how credentialing information is received, stored, reviewed, tracked and dated. These established policies and procedures help to ensure quality of care. The credentialing process utilizes the Uniform</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
Credentialing/Rec credentialing Provider Application through the Council for Affordable Quality Healthcare (CAQH) Universal Provider Data source to capture all required data and is compliant with National Committee for Quality Assurance (NCQA) and consistent with Louisiana Department of Health contract requirements. The IA Credentials Committee is supported by the Credentialing department, which conducts all verifications and credential file preparation.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		

Results for Standard VIII—Provider Selection							
<b>Total</b>	Met	=	18	X	1	=	18
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	19	<b>Total Score</b>	=	1/	

<b>Total Score ÷ Total Applicable</b>	= <b>95%</b>
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**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Standard IX—Subcontractual Relationships and Delegation**

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<b>General Rule</b>		
<p>1. Notwithstanding any relationship(s) that the MCE may have with any delegate, MCE maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.</p> <p style="text-align: right;">42 CFR §438.230(b)(1) 42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.8; 2.2.3.9 PAHP Contract: 1.4.2; 2.15.3; 2.15.6 PIHP Contract: 1.5.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1,6_Delegate Vendor Oversight and Mgmt Program P&amp;P_10.13.16.pdf, page 2, Section II</li> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 11, Exhibit A, Ensuring Appropriate Utilization Section</li> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, pages 18-19, Exhibit B, Provisions Section, items 3-6</li> <li>• 1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, pages 1-2, Provisions Section, items 3-4</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Executed AIM MOU</li> <li>• Amended and Restated Master Intercompany Agreement.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Healthy Blue ensures vendor performing services impacting Louisiana Medicaid Members receive, understand, and incorporate within their agreement with the MCO regulatory flown-down language that provides clarity to Anthem’s responsibilities under</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
the MCO Contract with the State. Through incorporation of the regulatory flow-down requirements, the vendor is required to adhere to the same requirements.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Contract or Written Arrangement		
<p>2. Each contract or written arrangement with a delegate must specify:</p> <ul style="list-style-type: none"> <li>a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.</li> <li>b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE’s contract obligations.</li> <li>c. The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or the MCE determine that the delegate has not performed satisfactorily.</li> </ul> <p style="text-align: right; margin-right: 50px;"> <i>42 CFR §438.230(b)(2)</i>  <i>42 CFR §438.230(c)(1)</i>  <i>42 CFR §457.1233(b)</i> </p> <p>MCO Contract: 2.2.3.4.1; 2.2.3.4.2; 2.2.3.4.3            PAHP Contract: 2.15.6.3; 2.15.9            PIHP Contract: 1.5.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Delegation agreement/contract template</li> <li>• HSAG will also use the results from the Delegation File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, pages 11-12, Exhibit A, UM Delegation Section</li> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, pages 12-13, MOU Exhibit A, Reporting Section</li> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, pages 18-19, Exhibit B, Provisions Section, items 3-6</li> <li>• 1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, pages 1-2, Provisions Section, items 3-4; pages 4-5, Section 25 and 27</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Merakey MSA Amendment 2</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Merakey SOW</li> <li>Merakey SOW Amendment 2</li> <li>American Specialty Health Group SOW 10</li> <li>SOW 10 Amendment 3</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue ensures vendor performing services impacting Louisiana Medicaid Members receive, understand, and incorporate within their agreement with the MCO regulatory flow-down language. The regulatory flow-down language ensures the vendor is aware of state-specific requirements that must be adhered to throughout the life of the agreement. A request to outsource a service is required to ensure proper due diligence is performed to identify a vendor. Once identified, during negotiation with the vendor, measurable metrics are built into the contract defining service standard required to be met per the MCO Contract and/or by Anthem. The vendor agreement incorporates language identifying a course of action if performance is unsatisfactory.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and MCO:</p> <p style="margin-left: 20px;">a. <i>rules, policies, procedures, manuals, the State Plan, and Waivers.</i></p> <p style="text-align: right; margin-right: 20px;"><i>42 CFR §438.230(c)(2)</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Delegation agreement/contract template</li> <li>HSAG will also use the results from the Delegation File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 1, Compliance with Louisiana Medicaid Regulation Section; page 18, Exhibit B, Provisions Section, item 3</li> <li>1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 11-12, Exhibit A, Ensuring Appropriate Utilization Section, UM Delegation Section,</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
	<p>and Compliance with Legal Requirements Section.</p> <ul style="list-style-type: none"> <li>1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 22, Exhibit B, Section 44</li> <li>1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, page 1, Provisions Section, item 3; page 2, Section 10; page 3, Section 15; page 5, Section 35</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narrative</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue ensures vendor performing services impacting Louisiana Medicaid Members receive, understand, and incorporate within their agreement with the MCO regulatory flow-down language that provides clarity to Anthem’s responsibilities under the MCO Contract with the State. Through incorporation of the regulatory flow-down requirements, the vendor is required to adhere to the same requirements. During delegate audits via our pre-delegation oversight an assessment is performed to validate vendors are in adherence with contractual and applicable federal, state, and accreditation standards, regulatory and NCQA reporting and continuous readiness reviews.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL’s written agreements did not comply with the federal or State language, which is exacting.</p>		
<p><b>Required Actions:</b> The MCE must ensure that all contracts or written arrangements indicate that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and rules, policies, procedures, manuals, the State Plan, and Waivers.</p>		
<p>4. The contract or written arrangement indicates, and the delegate agrees that:</p> <p style="margin-left: 20px;">a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books,</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Delegation agreement/contract template</li> <li>HSAG will also use the results from the Delegation File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



**Louisiana Department of Health  
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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State.</p> <p>b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.</p> <p>c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.</p> <p>d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.</p> <p style="text-align: right;"><i>42 CFR §438.230(c)(3)</i> <i>42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.5; 2.2.3.5.1; 2.2.3.5.2 PAHP Contract: 2.15.11.1; 2.15.11.1.1; 2.15.11.1.2; 2.15.11.1.3 PIHP Contract: 1.5.3.1</p>	<ul style="list-style-type: none"> <li>1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 16, Exhibit A, Access to Records Section</li> <li>1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 21, Exhibit B, Section 31; page 23, Exhibit B, Section 55</li> <li>1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, page 1, Provisions Section, item 3; pages 3-4, Section 22; and page 8, Section 51</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narrative</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue's pre-delegation audit may be performed on-site at the delegate/vendor facility, telephonically, via webinar and/or at the Company (desktop audit). The annual audit includes review of the contractor's written policies and procedures and documentation of quality activities in compliance with these standards. Anthem incorporates the regulatory flow-down requirements ensuring the vendor is aware of their obligations and adherence to the requirements.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL's written agreements did not comply with the federal language, which is exacting.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p><b>Required Actions:</b> The MCE must ensure that all contract or written arrangements indicate, and the delegate agrees that:</p> <ol style="list-style-type: none"> <li>a. The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCE's contract with the State.</li> <li>b. The delegate will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid members.</li> <li>c. The delegate agrees that the right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.</li> <li>d. That if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the delegate at any time.</li> </ol>		
<p>5. The contract or written arrangement: MCO:</p> <ol style="list-style-type: none"> <li>a. <i>Stipulates that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.</i></li> </ol> <p>42 CFR §438.230 42 CFR §457.1233(b) MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Delegation agreement/contract template</li> <li>• HSAG will also use the results from the Delegation File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, page 1, Compliance with Louisiana Medicaid Regulation Section; page 18, Exhibit B, Provisions Section, item 3</li> <li>• 1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, page 1, Provisions Section, item 3; page 5, section 35</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Narrative</li> </ul>	<p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Healthy Blue incorporates the regulatory flow-down requirements ensuring the vendor is aware of their obligations and adherence to the requirements.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL’s written agreements did not comply with the State’s conflicts of law provision.</p>		
<p><b>Required Actions:</b> The MCE must ensure its contracts or written arrangements stipulate that Louisiana law, without regard to its conflict of laws provisions, will prevail if there is a conflict between the State law where the Subcontractor is based and Louisiana law.</p>		
Monitoring and Auditing		
<p>6. Monitoring subcontractor’s performance shall be monitored:</p> <p>MCO:</p> <p>a. <i>On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.</i></p> <p>PAHP:</p> <p>a. <i>On an ongoing basis and subject to formal review according to a periodic schedule consistent with industry standards.</i></p> <p>PIHP:</p> <p>a. <i>The Subcontractor(s) will provide a written commitment to accept all Contract provisions and to comply with 42 CFR §438.3(k) and §438.230.</i></p> <p style="text-align: right;"><i>42 CFR §438.230 42 CFR §457.1233(b)</i></p> <p>MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Delegation agreement/contract template</li> <li>• Monitoring and audit documentation</li> <li>• Annual formal review</li> <li>• HSAG will also use the results from the Delegation File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1,6_Delegate Vendor Oversight and Mgmt Program P&amp;P_10.13.16.pdf, pages 15-19, Section III (A)(C)(D)(E)</li> <li>• 1-6_MOU to Master Intercompany Agr (Carelon MBM FKA AIM)_7.28.14.pdf, pages 16-17, Exhibit A, Annual Oversight Section; pages 18-19, Exhibit B, Provisions Section, items 3-6; page 21, Exhibit B, Provisions Section, item 34</li> <li>• 1-6_Louisiana Medicaid State-Specific Exhibit Template_10.22.24.pdf, pages 1-2, Provisions Section, items 3-4</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>6_Language Line Services_Audit_3.29.24.pdf, pages 1-5, all sections</li> <li>6_Carelon Health MBM Audit_11.8.24.pdf, pages 1-24, all sections</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue conducts oversight and monitoring of services/functions in accordance with the delegate/vendor agreement or with the terms and time frames of an approved Corrective Action Plan (CAP). The purpose of this oversight of the delegate’s/vendor’s performance is to evaluate whether the delegate/vendor is in compliance with their agreement and applicable federal, state, and accreditation standards; performs its activities in a successful manner that fulfills the delegate/vendor agreement requirements, Anthem and the State’s business needs and level of service expectations; needs to implement corrective actions to resolve potential areas of non-compliance or to address unsatisfactory delegate/vendor performance.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		

Results for Standard IX—Subcontractual Relationships and Delegation							
<b>Total</b>	Met	=	3	X	1	=	3
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	6	<b>Total Score</b>		=	3

<b>Total Score ÷ Total Applicable</b>	=	<b>50%</b>
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## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

### Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<b>Adoption of Practice Guidelines</b>		
<p>1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field.</p> <p style="text-align: right;">42 CFR §438.236(b)(1) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of adopted practice guidelines</li> <li>MCE-specific meeting minutes documenting committee review and approval</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5_QIQM-02A Final 2024.docx</li> <li>1-5_LA_CAID_Medicaid QIC Minutes Feb 2025_Final.pdf</li> <li>1-5_LA_CAID_CPG_Matrix.pf</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The practice guidelines are developed and updated by a multidisciplinary workgroup and are drawn from nationally recognized sources, ensuring they reflect current best practices and standards in medical care. The proposed guidelines are presented to the quality committee for review, input, and approval.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>2. The MCE adopts practice guidelines that consider the needs of the MCE’s members and:</p> <p>MCO:</p> <p>a. adopts clinical practice guidelines for at least the conditions listed below:</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of adopted practice guidelines</li> <li>MCE-specific meeting minutes documenting committee review and approval</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>i. Schizophrenia;</li> <li>ii. Attention Deficit Hyperactivity Disorder (ADHD);</li> <li>iii. Autism Spectrum Disorder;</li> <li>iv. Depression;</li> <li>v. Generalized Anxiety Disorder;</li> <li>vi. Post-Traumatic Stress Disorder;</li> <li>vii. Suicidal Behavior;</li> <li>viii. Oppositional Defiant Disorder;</li> <li>ix. Bipolar Disorder; and</li> <li>x. Substance Use Disorders.</li> </ul> <p>PIHP:</p> <ul style="list-style-type: none"> <li>a. develops clinical practice guidelines for:               <ul style="list-style-type: none"> <li>i. ADHD</li> <li>ii. Trauma Informed Care</li> <li>iii. Depression and Conduct Disorder</li> </ul> </li> </ul> <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(b)(2) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.2; 2.12.12.3 PAHP Contract: 2.5.5.1.2 PIHP Contract: 7.4.5.3; 7.4.7.1</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1-5_LA_CAID_CPG_Matrix.pdf</li> <li>• 1-5_QIQM-02A Final 2024.docx</li> <li>• 1-5_LA_CAID_Medicaid QIC Minutes Feb 2025_Finall.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> Practice guidelines addressing all the above conditions are included in the 2025 Clinical Practice Guidelines matrix.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>3. The MCE adopts practice guidelines that are adopted in consultation with network providers.</p> <p style="text-align: right;">42 CFR §438.236(b)(3) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of adopted practice guidelines</li> <li>MCE-specific meeting minutes documenting committee review and approval</li> <li>Evidence of consultation of network providers</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5_QIQM-02A Final 2024.docx</li> <li>1-5_LA_CAID_CPG_Matrix.pdf</li> <li>1-5_LA_CAID_Medicaid QIC Minutes Feb 2025_Final.pdf</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The CPG matrix was reviewed in January 2025. All current practice guidelines contained in the matrix were reviewed for updates. Potential additional practice guidelines are reviewed and vetted internally prior to being presented at the quality committee meeting</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>4. The MCE adopts practice guidelines that are:</p> <p>MCO/PAHP:</p> <p style="margin-left: 20px;">a. reviewed and updated periodically as appropriate.</p> <p>PIHP:</p> <p style="margin-left: 20px;">a. Reviewed annually and updated periodically as appropriate.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline</li> <li>MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p>b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines.</p> <p style="text-align: right;">42 CFR §438.236(b)(4) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract: 7.4.5.4; 7.4.7.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>1-5_QIQM-02A Final 2024.docx</li> <li>1-5_LA_CAID_CPG_Matrix.pdf</li> <li>1-5_LA_CAID_Medicaid QIC Minutes Feb 2025_Final.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> Each practice guideline within the CPG matrix is reviewed annually to ensure that the document is the most current version available.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Dissemination of Guidelines		
<p>5. The MCE disseminates the guidelines to:</p> <p style="margin-left: 20px;">a. All affected providers</p> <p style="margin-left: 20px;">b. Members and potential members, upon request</p> <p style="text-align: right;">42 CFR §438.236(c) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website)</li> <li>Evidence of dissemination to members (i.e., member newsletter, member handbook, member website)</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>5_QIQM-02A Final 2024</li> <li>LA_CAID_2025ClinicalPracticeGuidelinesNotification.pdf</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The CPG matrix and a separate notification is placed on the provider website. Providers or members can access the document via website or can call and request a paper copy of the document.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Application of Guidelines		
<p>6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.236(d) 42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Coverage guidelines/criteria</li> <li>Member educational guidance (i.e., disease management)</li> <li>Member materials (i.e., member handbook, member newsletters)</li> <li>Three examples of coverage denial notices</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>6_Utilization Management –LA Policy page 45</li> <li>6_Healthy Blue Member Handbook page 28, 92</li> <li>6_Examples Coverage Denial Notices.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> Utilization management decision process, member education, coverage of services, and other areas in which the guidelines apply are described in the Utilization Management-LA Policy, with additional information notated in the Healthy Blue Member Handbook.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Results for Standard X—Practice Guidelines						
<b>Total</b>	Met	=	6	X	1	= 6
	Not Met	=	0	X	0	= 0
	Not Applicable	=	0			
<b>Total Applicable</b>		=	6	<b>Total Score</b>	=	6

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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**Louisiana Department of Health**  
**2025 Compliance Review for Healthy Blue**

**Standard XI—Health Information Systems**

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<b>General Rule</b>		
<p>1. The MCE maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. The systems provide information on areas including, but not limited to:</p> <ul style="list-style-type: none"> <li>a. Utilization;</li> <li>b. Claims;</li> <li>c. Grievances and appeals; and</li> <li>d. Disenrollments for other than loss of Medicaid eligibility.</li> </ul> <p style="text-align: right; margin-right: 100px;">42 CFR §438.242(a) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies, procedures, and workflows</li> <li>• Systems integration mapping documentation</li> <li>• Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV])</li> <li>• Technical manual(s)</li> <li>• List of disenrollment codes (i.e., reasons for disenrollment) provided by the State</li> <li>• Screenshot of disenrollment codes available in the disenrollment system</li> <li>• HSAG will use the results from the information systems demonstration, including reporting capabilities</li> <li>• HSAG will use the results from the systems demonstrations</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Health Information Systems               <ul style="list-style-type: none"> <li>– 1-5_Elevance_GBD_MIS_v2.51.1.pdf, Entire Document (ED)</li> <li>– 1_Facets_Data Mapping_v6.10.004.pdf, ED</li> </ul> </li> <li>• ISCAT</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>- 1-5_Final 6_21_2024 Att 2_2024 LA_NAV_ISCAT.pdf, ED</li> <li>• a. Utilization               <ul style="list-style-type: none"> <li>- P&amp;P                   <ul style="list-style-type: none"> <li>▪ 1.a_Utilization Management - LA.pdf                       <ul style="list-style-type: none"> <li>▪ Page 63</li> </ul> </li> </ul> </li> <li>- System Integration                   <ul style="list-style-type: none"> <li>▪ 1-5_Elevance_GBD_MIS_v2.51.1.pdf, ED</li> <li>▪ 1_Facets_Data Mapping_v6.10.004.pdf, ED</li> </ul> </li> <li>- Technical Manual                   <ul style="list-style-type: none"> <li>▪ 1.a._Facets_Utilization_Management_Import_Subsystem_Guide_6_104RF56.pdf, ED</li> <li>▪ 1.a.b_Facets_Utilization_Management_Processing_User_Guide_6_107OK23.pdf, ED</li> <li>▪ 1.a.c_Facets_Utilization_Management_Reference_User_Guide_6_104FK49.pdf, ED</li> </ul> </li> </ul> </li> <li>• b. Claims               <ul style="list-style-type: none"> <li>- P&amp;P                   <ul style="list-style-type: none"> <li>▪ 1.b_GBD_P&amp;P_Claims Management System Capabilities.pdf, ED</li> </ul> </li> <li>- System Integration                   <ul style="list-style-type: none"> <li>▪ 1-5_Elevance_GBD_MIS_v2.51.1.pdf, pages 9, 10 &amp; 48</li> </ul> </li> </ul> </li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>▪ 1_Facets_Data Mapping_v6.10.004.pdf               <ul style="list-style-type: none"> <li>• Chapter 9</li> </ul> </li> <li>– Technical Manual               <ul style="list-style-type: none"> <li>▪ 1.b.a_Facets_Claims_User_Guide_6_10_3AV98.pdf</li> </ul> </li> <li>• c. Grievances and appeals               <ul style="list-style-type: none"> <li>– P&amp;P                   <ul style="list-style-type: none"> <li>▪ 1.c_Member Rights and Responsibilities - LA.pdf</li> </ul> </li> <li>– System Integration                   <ul style="list-style-type: none"> <li>▪ 1-5_Elevance_GBD_MIS_v2.51.1.pdf, pages 19, 20, 54 &amp; 55</li> </ul> </li> </ul> </li> <li>• d. Disenrollments               <ul style="list-style-type: none"> <li>– P&amp;P                   <ul style="list-style-type: none"> <li>▪ 1.c_Member Rights and Responsibilities - LA.pdf</li> </ul> </li> <li>– Technical Manual                   <ul style="list-style-type: none"> <li>▪ 1.d_LA Disenrollment and Enrollment.docx</li> </ul> </li> <li>– Disenrollment Codes                   <ul style="list-style-type: none"> <li>▪ 1.d_Medical Companion Guide - LA_EB_834_005010X220A1_Companion_Guide_2-11-25_v2.56.docx                       <ul style="list-style-type: none"> <li>▪ Appendix D – Maintenance Reason Codes, pages 49-51</li> <li>▪ Appendix I – MEDS Closure Codes, pages 58-59</li> </ul> </li> </ul> </li> </ul> </li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– Disenrollment Screenshot               <ul style="list-style-type: none"> <li>▪ 1.d_Disenrollment Screen Shots.pdf</li> </ul> </li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 1.c_Member Rights and Responsibilities - LA.pdf</li> <li>• 1_Database Back-Up and Restore Standard.pdf</li> <li>• 1_Healthy Blue BCP Overview_Pandemic_IT DR_MAY 2024_For External Release v2.pdf</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>Required Evidence</p> <ol style="list-style-type: none"> <li>1. Disenrollment Code: Not applicable to Grievance &amp; Appeals, Utilization, Claims, EVV, Provider Network or Encounter Data</li> <li>2. Technical Manual: Not applicable to Grievance &amp; Appeals</li> <li>3. System Integration: Not applicable to Disenrollments</li> </ol> <p>Healthy Blue supports Managed Care contracts with a fully integrated Management Information System (MIS) design. At the center of the design are five key integrated components: 1) Core Service Platform; 2) Health Insight Platform; 3) Data Warehouse; 4) Online Tools for Members &amp; Providers (e.g., Sydney Health); and 5) Supplemental Applications. The Core Service Platform is the system of record for member, provider, authorization and claims data. The Health Insight Platform is the source for member clinical and care coordination processes and data. The Data Warehouse serves as an integrated data repository for operations, analytics, and reporting. Sydney Health provides a public and secure self-service digital experience for members. The Provider Websites provide a public and secure self-service digital experience to providers. Together, the components effectively support all aspects of managed care.</p> <p>From an end-to-end perspective, credentialed providers, membership/eligibility, and contract benefits are loaded/configured in the Core Service Platform. This framework of information supports service authorizations, claims processing, and encounters. The Health Insight Platform relies on this framework of information to support the care coordination, utilization management, case management and disease management for members. Supplemental applications support quality, grievance and appeals processes and other tasks necessary to support member and provider functions. The Data Warehouse serves as a repository for all functional data used within the Core Service Platform and Health Insight Platform. The Data Warehouse supports regulatory, contractual and operational reporting and provides the information required for data extract</p>		



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Requirement	Supporting Documentation	Score
files sent to vendors and partners supporting the market. The Elevance_GBD_MIS document provides additional details regarding the integrated design used by Elevance Health / Healthy Blue to support managed care contractual requirements.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Basic Elements of a Health Information System		
<p>2. The MCE collects data on member and provider characteristics as specified by the State and on all services furnished to members through an encounter data system or other method as may be specified by the State.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.242(b)(2) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies, procedures, and workflows</li> <li>Claims data collection and processing guidelines</li> <li>Encounter data collection and submission guidelines</li> <li>HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Health Information Systems               <ul style="list-style-type: none"> <li>– 1-5_Elevance_GBD_MIS_v2.51.1.pdf                   <ul style="list-style-type: none"> <li>MIS Overview / Managed Care Functions, pages 5, 6 &amp;</li> <li>Enrollment – pages 7, 8 &amp; 47</li> <li>Claims – pages 9, 10 &amp; 48</li> <li>Encounters – pages 11, 12 &amp; 49</li> <li>Provider – pages 17, 18 &amp; 53</li> </ul> </li> </ul> </li> <li>ISCAT               <ul style="list-style-type: none"> <li>– 1-5_Final 6_21_2024 Att 2_2024 LA_NAV_ISCAT.pdf, ED</li> </ul> </li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• Claims               <ul style="list-style-type: none"> <li>– P&amp;Ps                   <ul style="list-style-type: none"> <li>▪ 2_GBD_RP_ClaimsSubProf.pdf, page 2</li> <li>▪ 2_GBD_RP_ClaimsSubFacilities.pdf, page 2</li> </ul> </li> </ul> </li> <li>• Data Collection &amp; Processing               <ul style="list-style-type: none"> <li>– 2_GBD_RP_ClaimsSubProf.pdf, page 2</li> <li>– 2_GBD_RP_ClaimsSubFacilities.pdf, page 2</li> </ul> </li> <li>• Encounter Submissions               <ul style="list-style-type: none"> <li>– 2,8,9_Systems Quality Assurance Plan - Encounter Data - LA.pdf, pages 2-4</li> </ul> </li> </ul>	
<p>The “Elevance_GBD_MIS” document illustrates information systems/functions currently used to load member and provider data, process claims, and report encounters to the State.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>3. The MCE ensures that data received from providers is accurate and complete by:</p> <ol style="list-style-type: none"> <li>a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments.</li> <li>b. Screening the data for completeness, logic, and consistency.</li> <li>c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for</li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies, procedures, and workflows</li> <li>• Claims submission requirements document</li> <li>• Claims data collection and processing guidelines</li> <li>• Claim validation processes</li> <li>• Claim timeliness reports</li> <li>• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>State Medicaid quality improvement and care coordination efforts.</p> <p style="text-align: right;">42 CFR §438.242(b)(3) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Health Information Systems               <ul style="list-style-type: none"> <li>– 1-5_Elevance_GBD_MIS_v2.51.1.pdf                   <ul style="list-style-type: none"> <li>▪ Claims – Pages 10, 11 &amp; 49</li> <li>▪ Care Coordination &amp; Care Management – Pages 14, 15 &amp; 52</li> <li>▪ Quality Management – Pages 15, 16 &amp; 52</li> <li>▪ Provider – Pages 17, 18 &amp; 53</li> <li>▪ Reporting – Pages 24, 25</li> <li>▪ Data Exchanges – Pages 34, 35 &amp; 36</li> </ul> </li> </ul> </li> <li>• ISCAT               <ul style="list-style-type: none"> <li>– 1-5 Final 6 21 2024 Att 2 2024 LA_NAV_ISCAT.pdf, ED</li> </ul> </li> <li>a. Claims - Accuracy &amp; Timeliness               <ul style="list-style-type: none"> <li>• 3.a_GBD_P&amp;P_Claim_Timely_Filing_Standard.pdf, ED</li> <li>• 3.a_LA_Timeliness_report_2024.xlsx, ED</li> </ul> </li> <li>b. Claims - Completeness, Logic &amp; Consistency               <ul style="list-style-type: none"> <li>• 3.b_GBD_End_to_End_Claim_Audit_Validation.pdf, ED</li> </ul> </li> <li>c. Claims - Data Collection &amp; Processing               <ul style="list-style-type: none"> <li>• 3.c_GBD_P&amp;P_Acknowledgement_of_Receipt_and_Received_Date_for EDI_Submissions.pdf, ED</li> </ul> </li> <li>c. Utilization Management - Data Collection &amp; Processing               <ul style="list-style-type: none"> <li>• 3.c_Health_Information_Systems_Utilization.pdf, ED</li> </ul> </li> </ul>	



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Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Healthy Blue acquires provider data from a variety of sources – to include the State, vendors, partners and applications. Data is securely transmitted based on pre-determined frequencies. Credentialing, NPI, demographic and location data is obtained, edited and loaded into Healthy Blue’s core systems and made available for Managed Care functions, such as claims processing.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>4. The MCE makes all collected data available to the State and upon request to CMS.</p> <p style="text-align: right; margin-right: 20px;">42 CFR § 438.242(b)(4) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies, procedures, and workflows</li> <li>HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b> Health Information Systems</p> <ul style="list-style-type: none"> <li>1-5_Elevance_GBD_MIS_v2.51.1.pdf               <ul style="list-style-type: none"> <li>– Encounters – pages 11, 12 &amp; 49</li> <li>– Reporting – pages 23, 24 &amp; 57</li> <li>– Data Exchanges – pages 33, 34 &amp; 35</li> </ul> </li> <li>ISCAT               <ul style="list-style-type: none"> <li>– 1-5_Final 6_21_2024 Att 2_2024 LA_NAV_ISCAT.pdf, ED</li> </ul> </li> <li>Reporting P&amp;Ps               <ul style="list-style-type: none"> <li>– 4.a_SOP_SANT-03_Requirements Gathering.docx, ED.docx</li> <li>– 4.b_SOP_SANT-11_Report_Testing_DEV.docx, ED.docx</li> </ul> </li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– 4.c_SOP_SANT-15_Report_Testing_QA.docx, ED.docx</li> <li>– 4.d_SOP_SANT-18_Report_Testing_PROD.docx, ED.docx</li> <li>• Technical Manual               <ul style="list-style-type: none"> <li>– 4.a_HLA_MCE_SCG_v.1_2025.06.18.pdf, ED.pdf</li> </ul> </li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 4.a_HLA_MCE_SCG_v.1_2023.09.20.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue ensures all collected data are made available, as needed through regulatory reporting and data exchanges to the State and CMS requirements. Daily copies of the required data are migrated to the reporting servers and used entirely for reporting and data extracts. In the event new data sources are required, the Data Management team meets with the appropriate data managers to determine the best approach to replicate data on the reporting server(s).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Claims Processing		
<p>5. The MCE complies with section 6504(a) of the Affordable Care Act and ensures its claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of section 1903(r)(1)(F) of the Act (electronic claims submission).</p> <p style="text-align: right;">42 CFR §438.242(b)(1) 42 CFR §457.1233(d) Affordable Care Act, Section 6504(a) Affordable Care Act, Section 1903(r)(1)(F)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies, procedures, and workflows</li> <li>• Claims data collection and processing guidelines</li> <li>• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Health Information Systems               <ul style="list-style-type: none"> <li>– 1-5_Elevance_GBD_MIS_v2.51.1.pdf</li> </ul> </li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7	<ul style="list-style-type: none"> <li>– Claims – pages 9, 10 &amp; 48</li> <li>• ISCAT               <ul style="list-style-type: none"> <li>– 1-5_Final 6_21_2024 Att 2_2024 LA_NAV_ISCAT.pdf, ED</li> </ul> </li> <li>• P&amp;P               <ul style="list-style-type: none"> <li>– 5_GBD_P&amp;P_Claims Management System Capabilities.pdf, ED</li> <li>– Data Collection &amp; Processing</li> <li>– 5_Workflow_Life Cycle of a Claim.pdf, ED</li> </ul> </li> <li>• Provider Manual               <ul style="list-style-type: none"> <li>– 5_Healthy Blue Provider Manual.pdf, ED</li> </ul> </li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 5_GBD_P&amp;P_Claims Management System Capabilities – LA.pdf</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue performs claims processing as outlined in the Healthy Blue Provider Manual. All claim types are accepted electronically, with very limited paper, from In-network and Out-of-Network providers and processed based on member eligibility and benefits plans. Pre-adjudicated claims are communicated back to the State via a daily file exchange (Shadow claims). Claims are adjudicated and the provider's explanation of payment/actual payment is sent to the provider as per their requested method – e.g., check or electronic payment.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<b>Application Programming Interface</b>		
<p>6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members’ personal representatives through the API as follows:</p> <ol style="list-style-type: none"> <li>a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and member cost-sharing pertaining to such claims, no later than one business day after a claim is processed;</li> <li>b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments;</li> <li>c. All other encounter data, including adjudicated claims and encounter data from any subcontractors.</li> <li>d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE;</li> <li>e. Information about covered outpatient drugs and updates to such information, including, where applicable, preferred drug list information, no later than one business day after the effective date of any such information or updates to such information.</li> </ol> <p style="text-align: right;">42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies, procedures, and workflows</li> <li>• API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc.</li> <li>• List of registered third-party applications</li> <li>• HSAG will use the results from the API demonstration</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCO:</b></p> <ul style="list-style-type: none"> <li>• P&amp;P               <ul style="list-style-type: none"> <li>– 6-7_Program Overview and Responsibilities for Digital Exchange Health Information and Data.pdf, pages 1, 2, 4 &amp; 6</li> </ul> </li> <li>• API Monitoring               <ul style="list-style-type: none"> <li>– 6-7_Program and Project status 04 25 25.pdf, ED</li> </ul> </li> <li>• Member Educational &amp; Website Materials               <ul style="list-style-type: none"> <li>– 6-7_privacy-guidance-third-party-apps-1030074MUMESMUBb.pdf, ED</li> <li>– Elevance Health’s Member facing privacy educational materials can be found on our website using the following URL: <a href="https://www.wellpoint.com/privacy">https://www.wellpoint.com/privacy</a> (“Privacy Guide when selecting Third-Party Apps to Receive Your Information”).</li> </ul> </li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>MCO Contract: None PAHP Contract: None PIHP Contract: None</p>	<ul style="list-style-type: none"> <li>• Developer Materials               <ul style="list-style-type: none"> <li>– The developer informational materials are available on our public facing developer website using the following URL: <a href="https://www.wellpoint.com/developers">https://www.wellpoint.com/developers</a> (“How to Access Our APIs &amp; Data   Wellpoint”)</li> </ul> </li> <li>• Programming Language               <ul style="list-style-type: none"> <li>– 6-7_Anthem-IOProviderDirectoryAndFormulary-API-Documentation.pdf, ED</li> </ul> </li> <li>• Data Update Mechanisms               <ul style="list-style-type: none"> <li>– 6-7_Program Overview and Responsibilities for Digital Exchange Health Information and Data.pdf, page 6</li> </ul> </li> <li>• List of Registered Third-Party Applications               <ul style="list-style-type: none"> <li>– Flexpa</li> <li>– MyDataHelps</li> <li>– DrOwl Health</li> <li>– Smart Health</li> <li>– Crescendo Health</li> <li>– TPA Stream</li> <li>– Healthcare Download</li> <li>– Goodbill</li> <li>– Guava</li> <li>– Budgie-Health</li> <li>– Truffle Health</li> </ul> </li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>- DataStream</li> <li>- Health Industries</li> <li>- CommonHealth</li> <li>- Rekencile</li> <li>- EnrollHere</li> <li>- UHC Interoperability and Patient Access Application</li> <li>- AaNeel Connect</li> <li>- OneRecord</li> <li>- AaNeel Freedom</li> <li>- EMR</li> <li>- Mpowered Health</li> <li>- Promise</li> <li>- AaNeelConnect - Optimum</li> <li>- AaNeelConnect - HealthSun</li> <li>- Neunetix</li> <li>- Fasten Health</li> <li>- Fasten Connect</li> <li>- AaNeelConnect - Ultimate Health Plan</li> <li>- AaNeelConnect - SECUR</li> <li>- WithCare</li> <li>- Unite</li> <li>- Claim Status Extraction</li> <li>- b.well Connected Health</li> <li>- My MC App</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– Metacare.ai</li> <li>– 1UpHealth Patient Connect</li> <li>– Flexfundr</li> <li>– CytoCync</li> <li>– Availity</li> <li>– Batomic</li> </ul>	
<p><b>MCE Description of Process:</b> API Documentation – Project Plan &amp; Testing Results are not applicable - Elevance Health’s Patient Access API was implemented and tested in 2021, hence there is no Project Plan or testing documentation to share within the specified Audit period. Healthy Blue has implemented a streamlined process for onboarding third-party applications through our developer portal. Each third-party application is granted secure credentials to access our API. By adhering to all specifications mandated by the CMS Patient Access Final Rule, Wellpoint ensures that appropriate authentication and authorization flows are in place for secure data exchanges. Detailed information about these established processes can be found in the attached document, "XI.6_Program Overview and Responsibilities for Digital Exchange of Health Information and Data.pdf."</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p> <p><b>Recommendations:</b> HSAG recommends that HBL prioritize continued Application Programming Interface (API) development as it is essential for not only enabling valuable business functions but also meeting federal regulatory requirements.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>7. The MCE maintains a publicly accessible standards-based API described in 42 CFR §431.70 (access to published provider directory information), which is conformant with the technical requirements at 45 CFR §431.60(c), excluding the security protocols related to user authentication and authorization and any other protocols that restrict the availability of this information to particular persons or organizations, the documentation requirements at 45 CFR</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies, procedures, and workflows</li> <li>• API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc.</li> <li>• List of registered third-party applications</li> <li>• HSAG will use the results from the web-based provider directory demonstration</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>§431.60(d), and is accessible via a public-facing digital endpoint on the MCO’s website.</p> <p style="text-align: right;">42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d)</p> <p>MCO Contract: -2.13.2.3 PAHP Contract: 2.9.2.1.2.1; 2.9.8.3.1; 2.13.1.6 PIHP Contract: 5.9.2.30; 5.10.1; 6.1.20</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• P&amp;P               <ul style="list-style-type: none"> <li>– 6-7_Program Overview and Responsibilities for Digital Exchange Health Information and Data.pdf, page 3</li> </ul> </li> <li>• API Monitoring               <ul style="list-style-type: none"> <li>– 6-7_Program and Project status 04 25 25.pdf, ED</li> </ul> </li> <li>• Stakeholder Materials               <ul style="list-style-type: none"> <li>– 6-7_privacy-guidance-third-party-apps-1030074MUMESMUBb.pdf, ED</li> <li>– Healthy Blue’s member facing privacy educational materials can be found on our website using the following URL: <a href="https://www.myhealthyblue.com/la/privacy.html">https://www.myhealthyblue.com/la/privacy.html</a></li> <li>– Data Update Mechanisms                   <ul style="list-style-type: none"> <li>○ 6-7_Program Overview and Responsibilities for Digital Exchange Health Information and Data.pdf, page 6</li> </ul> </li> </ul> </li> <li>• Programming Language               <ul style="list-style-type: none"> <li>– 6-7_Anthem-IOProviderDirectoryAndFormulary-API-Documentation.pdf, ED</li> </ul> </li> <li>• List of Registered Third-Party Applications               <ul style="list-style-type: none"> <li>– NetsyMD</li> <li>– Atlas Medical Data Group</li> </ul> </li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>- Defacto Health</li> <li>- Envision Health</li> <li>- Nextere LLC</li> <li>- eHealthInsurance Services, Inc</li> <li>- GroundGame.Health Inc.</li> <li>- CompuConsulting Group</li> <li>- McCollough Insurance Group LLC</li> <li>- Berry Street</li> <li>- Cloud Health Medical Group</li> <li>- TECQ Foundation</li> <li>- Unison Labs Inc.</li> <li>- UC Davis</li> <li>- Livmor</li> <li>- Commure</li> <li>- Health Reconconnect</li> <li>- RevueAI</li> <li>- Daffodil Health</li> <li>- CytoCync</li> </ul>	
<p><b>MCO Description of Process:</b> API Documentation – Project Plan &amp; Testing Results: Not applicable - Elevance Health’s Patient Access API was implemented and tested in 2021, hence there is no Project Plan or testing documentation to share within the specified Audit period. Healthy Blue has implemented a streamlined process for onboarding third-party applications through our developer portal. Each third-party application is granted secure credentials to access our API. By adhering to all specifications mandated by the CMS Patient Access Final Rule, Healthy Blue ensures that Provider Directory API includes the required information about its Network Providers for Primary Care Physicians, Specialists, hospitals, behavioral health Providers, managed long-term services and supports Providers as appropriate, and any other Providers contracted for Covered Services under Wellpoint’s contract(s) to the extent at which the information is in their system. Detailed information about these established processes can be found in the attached document, "XI.6_Program Overview and Responsibilities for Digital Exchange of Health Information and Data (Interoperability).pdf."</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p> <p><b>Recommendations:</b> HSAG recommends that the MCE ensure its public, searchable provider directory and Provider Directory API are updated to include all information specified in 42 CFR §438.10(h)(1-2), which also now includes whether the provider offers covered services via telehealth (effective July 1, 2025).</p>		
<p><b>Required Actions:</b> No action required.</p>		
Member Encounter Data		
<p>8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.</p> <p style="text-align: right;">42 CFR §438.242(c)(1) 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.1.1.1; 2.18.1.1.5 PAHP Contract: 2.14.2.1.3.1; 2.14.2.1.3.5 PIHP Contract: 15.2.2.3; 15.2.2.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies, procedures, and workflows –</li> <li>Encounter data collection requirements</li> <li>Two samples/screenshots of encounter data with rendering provider and item/service data fields (one sample must include encounter data from a sub-capitated source) -</li> <li>HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2,8,9_Systems Quality Assurance Plan - Encounter Data - LA.pdf, pages 2-4</li> <li>8_Rendering Provider Evidence_8,.docx, ED</li> <li>8, 9_Encounters_Business_Process_LA,.pdf, ED</li> <li>8, 9_837_Institutional_Companion_Guide.pdf, ED</li> <li>8, 9_837_Health_Care_Claim_Professional_non_emergency transportation.pdf, ED</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>8, 9_837_Health_Care_Claim_Professional.pdf, ED</li> <li>8, 9_837_Health_Care_Claim_Dental.pdf, ED</li> <li>8, 9_Batch_Pharmacy.pdf, ED</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue ensures the collection and maintenance of comprehensive member encounter data, which includes detailed information about the providers who deliver services to our members. The Encounters Management team is responsible for managing the encounter data within our internal system. By maintaining the claims detailed data, we can ensure that encounter submissions is complete and accurate.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>9. The MCO submits member encounter data to the State at a frequency and level of detail, based on program administration, oversight, and program integrity needs.</p> <p>a. The member encounter data includes all State-specific requirements for encounter data submissions, including allowed amount and paid amount, that the State is required to report to CMS under 42 CFR §438.818.</p> <p>b. The member encounter data is submitted to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.</p> <p>MCO:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly for all dates of service during the term of this Contract to LDH or the Fiscal Intermediary (FI) as directed by LDH</i></p> <p>PAHP:</p> <p>a. <i>Submit complete and accurate encounter data at least monthly.</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies, procedures, and workflows</li> <li>Encounter data submission requirements</li> <li>Three concurrent months/quarters of submission compliance (acceptance/rejection reports) -</li> <li>Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source)</li> <li>HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2,8,9_Systems Quality Assurance Plan - Encounter Data - LA.pdf, pages 2-4</li> <li>8, 9 Encounters_Business_Process_LA.pdf, ED</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XI—Health Information Systems		
Requirement	Supporting Documentation	Score
<p>PIHP:</p> <p style="margin-left: 20px;">a. <i>Submit complete and accurate encounter data at least weekly</i></p> <p style="text-align: right; margin-left: 100px;">42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d)</p> <p>MCO Contract: 2.18.15.3.1; 2.18.15.4 PAHP Contract: 2.14.2.1.3.5; 2.14.11.10; 2.14.11.4 PIHP Contract: 14.3.3.1; 15.2.2.9; 15.6.2.1</p>	<ul style="list-style-type: none"> <li>8, 9 837_Institutional_Companion_Guide.pdf, ED</li> <li>8, 9 837_Health_Care_Claim_Professional_non_emergency_transportation.pdf, ED</li> <li>8, 9 837_Health_Care_Claim_Professional.pdf, ED</li> <li>8, 9_837_Health_Care_Claim_Dental.pdf, ED</li> <li>8, 9_Batch_Pharmacy.pdf, ED</li> <li>9.a_Allowed and Paid Amount_9.docx, ED</li> <li>9.a_Accepted_Rejected_Report_9.docx, ED</li> </ul>	
<p><b>MCE Description of Process:</b> Healthy Blue follows the standardized X12 reporting protocols, ensuring adherence to contractual obligations during the encounter submission process. Encounter data is submitted through an automated process to state using 837 files. A HIPAA validator is employed to ensure compliance with the 837 transactions before submission. An automated process examines and maintains the integrity and completeness of the data. The encounters team monitors the timeliness, accuracy, and completeness of all encounter data through automated reports. State response files are analyzed to reconcile submissions, conducting thorough root-cause analysis of any errors, and devising strategies to prevent or rectify potential future submission issues.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		

Results for Standard XI—Health Information Systems							
<b>Total</b>	Met	=	9	X	1	=	9
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	9	<b>Total Score</b>		=	9

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

**Standard XII—Quality Assessment and Performance Improvement**

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<b>General Rules</b>		
<p>1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members.</p> <p style="text-align: right;">42 CFR §438.330(a)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• QAPI program description</li> <li>• QAPI program work plan</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 1-Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects(QIPs) Policy and Procedure; Pgs.1-6, 18-20</li> <li>• LA 2024 QM Program Description, Pgs. 6-7</li> <li>• LA 2024 Medicaid QM Workplan, Entire document</li> <li>• 1- Q1 LA QMC Presentation 03.20.2024; Pg 4</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The LA QAPI Program Description, Work Plan and Policies establishes an ongoing comprehensive quality assessment and performance QAPI Program dedicated at improving members’ health and the healthcare system.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<b>Basic Elements of QAPI Programs</b>		
<p>2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services.</p> <p style="text-align: right;">42 CFR §438.330(b)(3) 42 CFR §457.1240(b)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• QAPI program description</li> <li>• QAPI program work plan</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	<ul style="list-style-type: none"> <li>QAPI program evaluation</li> <li>Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports)</li> <li>Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Description, Pg. 32</li> <li>LA 2024 Medicaid QM Workplan; Tab titled 2024 Work Plan Activities, yellow highlight</li> <li>LA 2023 QM Program Evaluation, Pgs. 32-36; 38</li> <li>2.-2024 National CSC Charter; Pg. 3</li> <li>2- 2024 LA UM Evaluation; Pgs.7-12</li> <li>2- Utilization Management- LA Policy and Procedure; Pgs. 56 and 63</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> <li>2- LA Q3 CSC 8.14.2024 Committee Minutes; pgs. 41-42</li> <li>LA Q1 QMC 3.20.2024 minutes; pgs. 35-36</li> </ul>	
<p><b>MCE Description of Process:</b> The QAPI trilogy, Policies and Procedures, UM PD, detects over and under-utilization of services by monitoring and reviewing health plan services.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>3. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as identified by the State in the quality strategy.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.330(b)(4) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>QAPI program description</li> <li>QAPI program work plan</li> <li>QAPI program evaluation</li> <li>Definition of members with special health care needs</li> <li>Assessment tools</li> <li>Clinical guidance/criteria</li> <li>Metrics/performance measures to assess special health care needs</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Description, Pg. 32-34</li> <li>LA 2024 Medicaid QM Workplan; Found in Tabs 2024 Work Plan Activities (orange highlight) and Performance Measures (All)</li> <li>LA 2023 QM Program Evaluation; Pgs.18-23</li> <li>3-Tiered Case Management- LA Policy and Procedure; Pgs. 3-4;7</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b> The attached documents describe the internal mechanisms utilized in identifying and assessing the quality and appropriateness of care, including for individuals with special healthcare needs.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>4. The QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using long-term services and supports (LTSS), including:</p> <ul style="list-style-type: none"> <li>a. Assessment of care between care settings; and</li> <li>b. Comparison of services and supports received with those set forth in the member’s treatment/service plan, if applicable.</li> </ul> <p style="text-align: right; margin-right: 100px;">42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b)</p> <p>MCO Contract: NA PAHP Contract: None PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• QAPI program description</li> <li>• QAPI program work plan</li> <li>• QAPI program evaluation</li> <li>• Assessment tools</li> <li>• Clinical guidance/criteria</li> <li>• Metrics/performance measures to assess LTSS</li> <li>• Medical record audit tools and results</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• N/A</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA
<b>MCE Description of Process:</b> Not applicable		
<b>HSAG Findings:</b> Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<b>Performance Measurement</b>		
<p>5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually:</p> <ol style="list-style-type: none"> <li>a. Measures and reports to the State on its performance, using the standard measures required by the State;</li> <li>b. Submits to the State data, specified by the State, which enables the State to calculate the MCO’s performance using the standard measures identified by the State; or</li> <li>c. Performs a combination of the activities described in subelements (a) and (b).</li> </ol> <p style="text-align: right;">42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.2.3.4; 2.16.1.5 PAHP Contract: 2.11.1.1.2.3 PIHP Contract: 12.4.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• QAPI program description</li> <li>• QAPI program work plan</li> <li>• QAPI program evaluation</li> <li>• Performance measures reports</li> <li>• Evidence of submission of performance measurement reports to the State</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA 2024 QM Program Description, Pg. 30</li> <li>• LA 2024 Medicaid QM Workplan; Tab titled Performance Measures (All)</li> <li>• LA 2023 QM Program Evaluation; Pgs. 79-97</li> <li>• 5-05 Submission 11069 has been completed; Entire Documents (ED)</li> <li>• 05 11069_HEDIS_SIGNED</li> <li>• 05 AUDIT11069.csv</li> <li>• 05 AUDIT11069.xlsx</li> <li>• 05 CHILDCCC11069_DeIdentifiedMemberFile</li> <li>• 05 CHILDCCC11069_FinalCCCResults Report.pdf</li> <li>• 05 CHILDCCC11069_FinalCCCResults Report.xls</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>05 DATAWORKBOOK11069.xlsx</li> <li>05 VALIDATION11069.csv</li> <li>05 WORKBOOK11069.csv</li> <li>05 WORKBOOK11069.xml</li> <li>05 LA MCD MY 2023 Race Ethnicity and Rural Urban Stratification.xlsx</li> <li>5-Evidence of annual submission of all PIPs to the State; Entire Document</li> <li>5-Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy and Procedure; Pgs.1-6; 18-20</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> </ul>	
<p><b>MCE Description of Process:</b> The documents attached demonstrate that at least annually, Healthy Blue Louisiana collects HEDIS and other performance measure data and compares its performance to national benchmarks, state program performance, and prior health plan performance, as appropriate.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<b>Performance Improvement Projects</b>		
<p>6. The QAPI program includes performance improvement projects (PIPs).</p> <p style="padding-left: 20px;">a. The MCE conducts PIPs that focus on both clinical and nonclinical areas.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>QAPI program description</li> <li>QAPI program work plan</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>MCO: a. <i>The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.</i></p> <p>PIHP: a. <i>The PIHP shall perform a minimum of one LDH approved PIP.</i></p> <p style="text-align: right;">42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2</p>	<ul style="list-style-type: none"> <li>QAPI program evaluation</li> <li>List of all active PIPs, including which PIPs are considered clinical and non-clinical</li> <li>Documentation for all active PIPs</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>6- Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy and Procedure; Pgs. 18-20</li> <li>LA 2024 QM Program Description, Pg. 29-30</li> <li>LA 2024 Medicaid QM Workplan; Tab titled 2024 Work Plan Activities (Blue highlight)</li> <li>LA 2023 QM Program Evaluation; Pgs. 79-80</li> <li>6-Evidence of annual submission of all PIPs to the State</li> <li>6- LA_2024 PIP-Val BH TOC</li> <li>6-LA_2024_PIP-Val_Table 8c_BH</li> <li>6-LA_2024 PIP-Val Congenital Syphilis</li> <li>6-LA 2024_PIP-Val_CCS_Mar2025Final</li> <li>6- LA_2024 PIP-Val Fluoride Varnish</li> <li>6- LA2024_PIP Val_HIV_Submission</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Performance improvement projects (PIPs) are a subset of all improvement projects that must comply with 42 CFR 438.330. Healthy Blue Louisiana conducts PIPs that focus on both clinical and nonclinical areas, as required by the State.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements:</p> <ol style="list-style-type: none"> <li>a. Measurement of performance using objective quality indicators.</li> <li>b. Implementation of interventions to achieve improvement in the access to and quality of care.</li> <li>c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State.</li> <li>d. Planning and initiation of activities for increasing or sustaining improvement.</li> </ol> <p style="text-align: right; margin-right: 50px;">42 CFR §438.330(d)(2) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• QAPI program description</li> <li>• QAPI program work plan</li> <li>• QAPI program evaluation</li> <li>• Policies and procedures</li> <li>• Documentation for all active PIPs</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA 2024 QM Program Description, Pg. 29</li> <li>• LA 2024 Medicaid QM Workplan; Tab titled Perf. Improvement Projects (All)</li> <li>• LA 2023 QM Program Evaluation; Pgs.80-97</li> <li>• 7- Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy and Procedure; Pgs.1-6; 18-20</li> <li>• 7-Evidence of annual submission of all PIPs to the State</li> <li>• 7- LA_2024 PIP-Val BH TOC</li> <li>• 7- LA_2024 PIP-Val Behavioral Health</li> <li>• 7- LA_2024 PIP-Val Congenital Syphilis</li> <li>• 7- LA_2024 PIP-Val CCS</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>7- LA_2024 PIP-Val Fluoride Varnish</li> <li>7- LA_2024 PIP-Val HIV</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> </ul>	
<p><b>MCE Description of Process:</b> Each PIP is designed to achieve significant improvement, sustained over time in population health outcomes, including health equity, quality of life, and member satisfaction across the continuum of care.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year.</p> <p style="text-align: right;">42 CFR §438.330(d)(3) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIP Contract: 12.5.4.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Evidence of annual submission of all PIPs to the State</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>8- Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) Policy and Procedure; Pg.19</li> <li>LA 2024 QM Program Description, Pg. 29</li> <li>8-Evidence of annual submission of all PIPs to the State</li> <li>8- LA_2024 PIP-Val BH TOC</li> <li>8- LA_2024 PIP-Val Behavioral Health</li> <li>8- LA_2024 PIP-Val Congenital Syphilis</li> <li>8- LA_2024 PIP-Val CCS</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>8- LA_2024 PIP-Val Fluoride Varnish</li> <li>8- LA_2024 PIP-Val HI</li> </ul>	
<b>MCE Description of Process:</b> The attached documents are evidence that Healthy Blue Louisiana reports the status and results of each PIP to the State annually, or as required by the state.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Critical Incidents		
<p>9. The QAPI program includes participation in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare per 42 CFR §441.302 and §441.730(a) that are based, at a minimum, on the requirements for home and community-based waiver programs per 42 CFR §441.302(h).</p> <p style="margin-left: 40px;">42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>QAPI program description</li> <li>QAPI program work plan</li> <li>QAPI program evaluation</li> <li>Three examples of critical incident reports</li> <li>Committee meeting minutes</li> <li>Provider remediation plan template(s)</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>9-Quality of Care-Core Procedure, Pgs. 1-11</li> <li>LA 2024 QM Program Description, Pg. 34</li> <li>LA 2024 Medicaid QM Workplan; Tab titled 2024 Work Plan Activities (Green highlight)</li> <li>LA 2023 QM Program Evaluation, Pg. 43</li> <li>9-0326_Adverse_Incident_Report_August2024</li> <li>9-0326 Adverse_Incident_Report December2024</li> <li>9-0326_Adverse_Incident_Report Nov2024</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The other documents provided outline the active involvement in state-led initiatives aimed at preventing, detecting, and addressing critical incidents.</p>		
<p><b>HSAG Findings:</b> Home and Community-Based Services waiver responsibilities are managed by the State through the fee-for-service (FFS) program and not through the MCEs; therefore, HSAG has determined that this requirement is not applicable.</p>		
<p><b>Required Actions:</b> No action required.</p>		
QAPI Program Reviews, Analysis, and Evaluation		
<p>10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:</p> <ul style="list-style-type: none"> <li>a. The performance on the measures on which it is required to report.</li> <li>b. The outcomes and trended results of each PIP.</li> <li>c. The results of any efforts to support community integration for members using LTSS.</li> </ul> <p>MCO:</p> <ul style="list-style-type: none"> <li>a. <i>The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.</i></li> </ul> <p style="text-align: right; margin-right: 20px;">42 CFR §438.330(e) 42 CFR §457.1240(b)</p> <p>MCO Contract: 2.16.6.2; 2.16.3.1; 2.16.7.1.2; 2.16.7.1.3 PAHP Contract: 2.11.2.3.1.2; 2.11.2.4.1.3 PIHP Contract: 12.2.3.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Committee meeting minutes (with discussion of QAPI evaluation)</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 10 LA Q1 QMC 3.20.2024 minutes Final Approved Signed</li> <li>• 10 LA Q2 QMC 06.25.2024 Minutes Final Approved Signed</li> <li>• 10 LA Q3 QMC 9.26.2024_Final Signed</li> <li>• 10 LA Q4_QMC_12.18.24_Minutes Final</li> <li>• 10-LA Q1-Q4 2024 QMC Presentations; Entire Documents</li> <li>• LA 2024 Medicaid QM Work Plan; Tab titled Performance Measures (All)</li> <li>• LA 2023 QM Program Evaluation, Pgs. 99-101</li> <li>• 10-Evidence of annual submission of all PIPs to the State</li> <li>• 10 LA Q1 QMC Presentation.pdf</li> <li>• 10 Q2 LA QMC Presentation.pdf</li> <li>• 10 LA Q3 2024 QMC Presentation.pdf</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>10 LA Q4 2024 QMC Presentation.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA 2024 QM Program Evaluation to cover all required elements.</li> </ul>	
<p><b>MCE Description of Process:</b> The documents provided indicate that the MCE develops a process to evaluate the impact and effectiveness of its QAPI Program, including performance on required measures and outcomes and trends of each PIP, with oversight and evaluation by the MCO's governing body.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>11. QAPI Committee Requirements:</p> <p>MCO:</p> <ol style="list-style-type: none"> <li>a. <i>The MCO forms a QAPI Committee that at a minimum includes:</i> <ol style="list-style-type: none"> <li>i. <i>The MCO's Medical Director who must serve as either the chairman or co-chairman;</i></li> <li>ii. <i>The MCO's Behavioral Health Director;</i></li> <li>iii. <i>Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;</i></li> <li>iv. <i>Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and</i></li> <li>v. <i>An Enrollee representative(s) and/or advocate(s).</i></li> </ol> </li> </ol> <p>PAHP:</p> <ol style="list-style-type: none"> <li>a. <i>The PAHP shall form a QAPI Committee that shall, at a minimum include:</i></li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>QAPI committee meeting minutes</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>11-LA Q1 QMC 03.20.2024 minutes final Approved Signed; Pgs. 1-3</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>11- 2024 HEAC Consumer Advisory Charter; pgs. 1-2</li> <li>11-2024 QMC Charter; Entire Document</li> <li>11- LA 2024 Appendix C Committee Structure chart; Entire Document</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>i. <i>The Dental Director who must serve as either the chairman or co-chairman;</i></li> <li>ii. <i>Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and</i></li> <li>iii. <i>The PAHP shall include an enrollee advocate representative on the QAPI Committee.</i></li> </ul> <p>PIHP:</p> <ul style="list-style-type: none"> <li>a. <i>The PIHP shall form a QAPI committee that shall, at a minimum include:</i> <ul style="list-style-type: none"> <li>i. <i>The PIHP’s Medical Director, who must serve as the chair or co-chair and</i></li> <li>ii. <i>Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and corporate compliance administrator responsible for fraud, waste and abuse activities.</i></li> </ul> </li> </ul> <p>MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1</p>		
<p><b>MCE Description of Process:</b> The documents specify that the QAPI Committee includes the Medical Director as chairman or co-chairman, the Behavioral Health Director, substantial representation from medical and behavioral health providers, appropriate departmental staff, and an enrollee representative or advocate.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>12. QAPI Committee Responsibilities:</p> <p>MCO:</p> <p>a. <i>The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:</i></p> <p>i. <i>Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;</i></p> <p>ii. <i>Ensure that QAPI activities take place throughout the MCO’s organization and ensure that providers are involved in the QAPI Program;</i></p> <p>iii. <i>Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;</i></p> <p>iv. <i>Create and direct task forces/committees to identify, review, and address areas of concern in the provision of health care services to Enrollees, including instituting needed action and ensuring that appropriate follow-up occurs;</i></p> <p>v. <i>Designate evaluation and study design procedures;</i></p> <p>vi. <i>Review provider network performance, including individual primary care provider (PCP), specialized behavioral health provider, and practice quality performance measure profiling to identify and address patterns;</i></p> <p>vii. <i>Report findings to appropriate executive authority, staff, and departments within the MCO’s organization;</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• QAPI committee meeting minutes</li> <li>• Evidence of submission to the State</li> <li>• Evidence of working with other Contractor staff and Subcontractors</li> <li>• Evidence of updates to the Provider Manual</li> <li>• Evidence of provider network performance reviews</li> <li>• Evidence of provider quality performance measure profiling</li> <li>• Evidence of periodic reviews of members’ service utilization patterns</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 12a LA Q1 QMC 3.20.2024 minutes Final Approved Signed.pdf</li> <li>• 12a LA Q2 QMC 06.25.2024 Minutes Final Approved Signed.pdf</li> <li>• 12a LA Q3 QMC 9.26.2024_Final Signed.pdf</li> <li>• 12a LA Q4_QMC_12.18.24_Minutes Final</li> <li>• 12- LA 136 HBL 2024 QAPI Program Description, Work Plan, Impact and Effectiveness of Program Evaluation; Entire Document</li> <li>• 12 CHILDCCC11069_DeIdentified MemberFile</li> <li>• 12 CHILDCCC11069_FinalCCCRResultsReport</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>viii. <i>Direct and analyze periodic reviews of Enrollees' service utilization patterns;</i></p> <p>ix. <i>Maintain written minutes of all committee and sub-committee meetings and submit meeting minutes to LDH. A copy of the signed and dated written minutes for each meeting shall be available after the minutes are approved and shall be available for review upon request and during EQRO reviews and during NCQA accreditation reviews;</i></p> <p>x. <i>Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;</i></p> <p>xi. <i>Ensure that the QAPI Committee chair, and/or the appropriate designee, participates in LDH's Quality Committee meetings and other quality related meetings as required;</i></p> <p>xii. <i>Work with other Contractor staff and Subcontractors to establish policies and procedures to address specific quality concerns as required by this section of this Contract; and</i></p> <p>xiii. <i>Update provider manuals and other relevant clinical content on a periodic basis as often as determined necessary by the committee chairperson.</i></p> <p>PAHP:</p> <p>a. <i>The QAPI Committee shall:</i></p> <p style="margin-left: 20px;">i. <i>Meet on a quarterly basis;</i></p> <p style="margin-left: 20px;">ii. <i>Direct and review quality improvement (QI) activities;</i></p>	<ul style="list-style-type: none"> <li>• 12 CHILDCCC11069_FinalGPRResultsReport</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LA 2024 QM Program Evaluation to cover all required elements.</li> <li>• 12ai- LA 2024 QM Program Evaluation; Entire Document</li> <li>• 12aaii-2024 Mac Charter; Entire Doc; 2024 QM PD; Entire Doc; 2024 Work Plan; Entire Document; LA 2024 QM Evaluation; Entire Document</li> <li>• 12aiii- LA Q1 QMC 3.20.2024 minutes; pgs. 37-39</li> <li>• 12aiv- LA Q1 QMC 3.20.2024 minutes; pgs. 51-54</li> <li>• 12av- Study Selection, Design, Implementation and Evaluation: Quality Improvement Projects (QIPs) P&amp;P; pgs. 1-7; LA 2024 QM Program Evaluation; Entire Document</li> <li>• 12avi- Q1 LA 2024 SQC 3.15.2024 meeting minutes; pgs.37-41</li> <li>• 12avii- 2024 Appendix A Corporate Committees; Entire Document</li> <li>• 12aviii- LA Q3 CSC 08.14.2024 minutes; pgs. 39-42</li> <li>• 12aix- LA Q1 QMC 3.20.2024 minutes; pgs. 1-3;55</li> <li>• 12ax-LDH Report Approval 0136 HBL 2024 screenshot; Entire Document</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>iii. <i>Ensure that QAPI activities are implemented throughout the PAHP;</i></li> <li>iv. <i>Review and suggest new and/or improved QI activities;</i></li> <li>v. <i>Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;</i></li> <li>vi. <i>Designate evaluation and study design procedures;</i></li> <li>vii. <i>Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;</i></li> <li>viii. <i>Report findings to appropriate executive authority, staff, and departments within the PAHP;</i></li> <li>ix. <i>Direct and analyze periodic reviews of enrollees' service utilization patterns;</i></li> <li>x. <i>Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and</i></li> <li>xi. <i>Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.</i></li> </ul> <p>PIHP:</p> <ul style="list-style-type: none"> <li>a. <i>QAPI committee responsibilities shall include:</i> <ul style="list-style-type: none"> <li>i. <i>Directing and reviewing QI activities;</i></li> <li>ii. <i>Ensuring that QAPI activities take place throughout the organization;</i></li> <li>iii. <i>Suggesting new and/or improved QI activities;</i></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 12axi- MAC Meeting Minutes 11.12.2024; pg.1</li> <li>• 12axii- EDOM GBD Policy and Procedure; pg.15</li> <li>• 12axiii- 2024 QM Workplan; Line 45, under 2024 Work Plan Activities, yellow highlight</li> </ul>	



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Requirement	Supporting Documentation	Score
<p>iv. <i>Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;</i></p> <p>v. <i>Conducting provider quality performance measure profiling;</i></p> <p>vi. <i>Reporting findings to appropriate executive authority, staff, and departments within the PIHP;</i></p> <p>vii. <i>Directing and analyzing periodic reviews of members' service utilization patterns; and</i></p> <p>viii. <i>Maintaining minutes of all committee and sub-committee meetings and submitting meeting minutes, agendas, and referenced materials to LDH within five (5) business days following the meeting. The PIHP shall submit draft meeting minutes within five (5) business days following the meeting, if the final meeting minutes are not approved by the QAPI committee within five (5) business days following the meeting.</i></p> <p>MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2</p>		
<p><b>MCE Description of Process:</b> The documents confirm that the QAPI Committee meets quarterly to oversee, evaluate, and direct QM/QI activities throughout the MCO, ensuring provider involvement, and reports findings to appropriate parties.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p> <p><b>Recommendations:</b> HSAG recommends that the MCE add a section with its Quality Management Program Description to list the committee responsibilities that are contract requirements.</p>		
<p><b>Required Actions:</b> No action required.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>13. QAPI Plan Requirements: MCO:</p> <p>a. <i>The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.</i></p> <p>b. <i>The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually thereafter, and prior to implementation of revisions.</i></p> <p>c. <i>The QAPI Plan, at a minimum, shall:</i></p> <p style="margin-left: 20px;">i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i></p> <p style="margin-left: 20px;">ii. <i>Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;</i></p> <p style="margin-left: 20px;">iii. <i>Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;</i></p> <p style="margin-left: 20px;">iv. <i>Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;</i></p> <p style="margin-left: 20px;">v. <i>Be exclusive to the Louisiana Medicaid Program and shall not contain documentation from other State Medicaid programs or product lines operated by the Contractor; and</i></p> <p style="margin-left: 20px;">vi. <i>Describe the methods for ensuring data collected and reported to LDH is valid, accurate, and reflects Network Providers' adherence to clinical practice guidelines as appropriate.</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• QAPI Plan</li> <li>• Evidence of submission to the State</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 13-2024 National QMC Charter LA Final Approved 3.20.2024; Entire Document</li> <li>• 13a-c - 136 HBL 2024 LA QAPI Program Description, Work Plan, Impact and Effectiveness of Program Evaluation; Entire Document</li> <li>• 13_ 2024 Appendix A Corporate Committee; Pgs. 1-2; 3-8</li> <li>• 13 LA 2024 Appendix C Committee Structure Chart Final Approved; Entire Document</li> <li>• 13_ LA 2024 Appendix D: Provider Support Plan; Entire Document</li> <li>• 13_ LA 2024 Organizational Structure Final Approved; Entire Document</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 13ciii- Appendix A Corporate Committees; Entire Document</li> <li>• 13ciii- LA 2024 QM Program Description; pgs. 12-16</li> <li>• 13ciii- 2024 QM Work Plan; Purple tab titled “LA Health Plan Staff”; Entire Document</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>PAHP:</p> <ul style="list-style-type: none"> <li>a. <i>The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.</i></li> <li>b. <i>The QAPI plan shall be submitted to LDH annually, and prior to revisions.</i></li> <li>c. <i>The QAPI plan, at a minimum, shall:</i> <ul style="list-style-type: none"> <li>i. <i>Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;</i></li> <li>ii. <i>Include processes to evaluate the impact and effectiveness of the QAPI Program;</i></li> <li>iii. <i>Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and</i></li> <li>iv. <i>Describe the role of providers in giving input to the QAPI Program.</i></li> </ul> </li> </ul> <p>PIHP:</p> <ul style="list-style-type: none"> <li>a. <i>The QAPI committee shall develop and implement a written QAPI program description and work plan, which must be submitted to LDH within thirty (30) days of Division of Administration, Office of State Procurement (DOA/OSP) approval of the signed Contract and annually thereafter. The combined QAPI program description and work plan shall not exceed 30 pages unless otherwise approved by Office of Behavioral Health, Louisiana Department of Health (OBH).</i></li> <li>b. <i>The QAPI program description at a minimum, shall:</i></li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>i. <i>Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.</i></li> <li>ii. <i>Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.</i></li> <li>iii. <i>Specify the remediation actions that will be implemented when system performance is less than the required threshold.</i></li> <li>iv. <i>Demonstrate that active processes are in place that measure associated outcomes for assessing quality performance, identifying opportunities for improvement, initiating targeted quality interventions, and regularly monitoring each intervention’s effectiveness.</i></li> <li>v. <i>Describe how the Contractor will obtain feedback from providers and members.</i></li> <li>vi. <i>Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.</i></li> <li>vii. <i>Be exclusive to the Coordinated System of Care (CSoC) Program and shall not contain documentation from other state Medicaid programs or product lines operated by the Contractor.</i></li> <li>c. <i>The QAPI work plan at a minimum shall: Include objectives for the Contract year, inclusive of associated action steps and timelines.</i></li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<p>i. <i>Include metrics and associated benchmarks for the wraparound agency scorecard.</i></p> <p>ii. <i>Include a fidelity monitoring plan that includes utilization of a standardized fidelity monitoring tool to ensure the core elements of the wraparound facilitation are maintained, in accordance to the standards of practice established by the National Wraparound Initiative (NWI). The Contractor must conduct fidelity monitoring on an annual basis to ensure that the wraparound agencies (WAAs) adhere to evidence-informed practices. The fidelity plan at a minimum shall include the fidelity criteria for the sampling approach, data collection methods, tools to be used, frequency of review, and validation methods.</i></p> <p>iii. <i>Include a plan to evaluate ongoing implementation of high-fidelity Wraparound in accordance with National Wraparound Initiative (NWI) standards inclusive of best practice indicators approved by OBH. The plan shall include a formalized monitoring review process of wraparound facilitator’s (WF) demonstration of established wraparound competencies on a quarterly basis.</i></p> <p>MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3</p>		
<p><b>MCE Description of Process:</b> The documents provided confirm that the QAPI Plan requirements for the MCO are met by developing and implementing a written plan incorporating strategic direction from the governing body, submitting the plan to LDH during Readiness Review and annually, ensuring a coordinated strategy with evaluation metrics, detailing staff responsibilities and involvement from Network Providers and Enrollees, and focusing exclusively on the Louisiana Medicaid Program with valid and accurate data collection methods.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XII—Quality Assessment and Performance Improvement		
Requirement	Supporting Documentation	Score
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		

Results for Standard XII—Quality Assessment and Performance Improvement							
<b>Total</b>	Met	=	11	X	1	=	11
	Not Met	=	0	X	0	=	0
	Not Applicable	=	2				
<b>Total Applicable</b>		=	11	<b>Total Score</b>	=	11	

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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**Louisiana Department of Health  
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**Standard XIII—Grievance and Appeal Systems**

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<b>Grievance System General Requirements</b>		
<p>1. The MCE defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination (ABD). Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the MCE to make an authorization decision.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Complaints and Grievances Policy – LA top of pg. 3</li> <li>• Healthy Blue Member Handbook middle of pg.78</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Definition of a grievance found in our Member Grievance Policy and the Member Handbook.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>2. A member may file a grievance with the MCE at any time.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Member consent form template</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(2)(i) 42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1</p>	<ul style="list-style-type: none"> <li>HSAG will also use the results of the Grievances File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Complaints and Grievances Policy – LA middle of pg. 4</li> <li>Healthy Blue Member Handbook middle of pg.78</li> <li>Appeal and Consent Request Form</li> </ul>	
<b>MCE Description of Process:</b> The authorized consent form is a form used for members to authorize others to file grievances on their behalf.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>3. The member may file a grievance either orally or in writing.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.1.8; 11.3.6.1; 11.3.6.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>HSAG will also use the results of the system demonstration</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Complaints and Grievances Policy – LA middle of pg. 4</li> <li>Healthy Blue Member Handbook bottom of pg.78</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Members may file grievances orally or in writing.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<b>Handling of Grievances</b>		
<p>4. The MCE acknowledges receipt of each grievance. MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>The MCO’s/PAHP’s process for handling enrollee grievances shall include acknowledgement in writing within five (5) business days of receipt of each grievance.</i></p> <p>PIHP:</p> <p style="margin-left: 20px;">a. <i>Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.</i></p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Grievance acknowledgment notice template</li> <li>Tracking and reporting mechanisms</li> <li>HSAG will also use the results of the Grievances File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Complaints and Grievances Policy – LA bottom of pg.6</li> <li>Member Grievance Ack Letter</li> <li>Member Grievance Acknowledgement Tracking System</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Healthy Blue acknowledges receipt of grievances within three (3) business days. Also included is a screenshot of the grievance acknowledgement tracking system.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The policy submitted included language that if a grievance was resolved the same day it was received, it would be waived. During the virtual review, HBL staff members explained that if the MCE’s member services department resolved the matter during the initial contact, these grievances were not forwarded to the appeals and grievances department and did not follow the full grievance procedure to meet requirements (acknowledgement, investigation, resolution).</p>		
<p><b>Required Actions:</b> The MCE must ensure that for all grievances (i.e., any expression of dissatisfaction, complaints), even if the matter is immediately resolved, the proper procedures are followed to resolve each grievance and provide notice as expeditiously as the member’s health</p>		



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Requirement	Supporting Documentation	Score
<p>condition requires, within 90 calendar days from the day on which the MCE receives the grievance. If any expression of dissatisfaction is present, the MCE must classify and treat the matter as a grievance, report to the State, follow the requirements for grievance acknowledgement, provide resolution, and ensure that members are granted their full rights. The MCE must revise its policy to adhere to the federal requirement to acknowledge receipt of each grievance by sending an acknowledgement letter.</p>		
<p>5. The MCE ensures that the individuals who make decisions on grievances are individuals:</p> <p>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</p> <p>b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:</p> <p>i. A grievance regarding denial of expedited resolution of an appeal.</p> <p>ii. A grievance that involves clinical issues.</p> <p>c. Who take into account all comments, documents, records, and other information submitted by the member or their representative.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.3 PAHP Contract: 2.10.1.3 PIHP Contract: 11.4.1.1.3; 11.4.1.1.3.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Organizational chart of grievance staff members, including credentials</li> <li>• HSAG will also use the results of the Grievances File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Complaints and Grievances Policy – LA top of pg. 6</li> <li>• Grievance Org Chart</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The grievance team is a separate unit that has no input on an original decision. Organizational chart showing grievance team and leadership.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<b>Timely Resolution and Notification of Grievances</b>		
<p>6. The MCE resolves each grievance, and provides notice, as expeditiously as the member’s health condition requires, within State-established timeframes that do not exceed the timeframes specified in 42 CFR §438.408.</p> <p>MCO and PAHP Standard Grievances</p> <p>a. <i>The MCO/PAHP shall review the grievance and provide written notice to the enrollee of the disposition of a grievance no later than ninety (90) Calendar Days from the date the MCO/PAHP receives the grievance.</i></p> <p>PIHP Standard Grievances</p> <p>a. <i>For standard resolution of a grievance and notice to the affected parties, the timeframe is established as thirty (30) calendar days or less (depending on applicable waivers) from the day the Contractor receives the grievance.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12)</p> <p>MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Grievance resolution notice template or oral notification script</li> <li>• Tracking and reporting mechanisms</li> <li>• HSAG will use the Universe File to evaluate timeliness</li> <li>• HSAG will also use the results of the Grievances File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Complaints and Grievances Policy – LA top of pg. 7</li> <li>• Grievance Resolution Letter</li> <li>• LA 010 August 2024 Monthly Grievance Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> See the Member Complaints and Grievances Policy and the Grievance Resolution Letter template showing language around ensuring grievance is completely timely. Also provided is the Monthly LA 010 state report which highlights internal tracking.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms</li> <li>Two examples of a grievance with extensions with LDH approval</li> <li>HSAG will use the Universe File to evaluate timeliness</li> <li>HSAG will also use the results of the Grievances File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Tracking sheet for grievance extensions</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> There were no grievance extensions requested and there is no letter for grievance extensions.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL did not submit evidence of a policy or procedure for the MCE to extend the time frame for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p>		
<p><b>Required Actions:</b> The MCE must develop and implement a policy and procedure to extend the time frame for resolving grievances by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p>		



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Requirement	Supporting Documentation	Score
<p>8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following:</p> <p style="margin-left: 20px;">a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p style="margin-left: 20px;">b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Grievance extension template letter</li> <li>Two examples of grievances with extensions with oral and written notice</li> <li>HSAG will also use the results of the Grievances File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li></li> </ul>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> There were no grievance extensions requested and there is no letter for grievance extensions.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. HBL did not submit evidence of a policy or procedure that included that if the MCE extends the grievance resolution time frame not at the request of the member, it completes all of the following:</p> <p style="margin-left: 20px;">a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p style="margin-left: 20px;">b. Within two calendar days gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision.</p>		
<p><b>Required Actions:</b> The MCE must develop and implement a policy and procedure that if it extends the grievance resolution time frame not at the request of the member, it completes all of the following:</p> <p style="margin-left: 20px;">a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p style="margin-left: 20px;">b. Within two calendar days gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision.</p>		



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Requirement	Supporting Documentation	Score
<b>Appeals General Requirements</b>		
<p>9. The MCE defines an appeal as a review by the MCE of an ABD.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii)</p> <p>MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) bottom of pg. 4</li> <li>• Healthy Blue Member Handbook bottom of pg.79 (PDF pg. 80)</li> <li>• Healthy Blue Provider Manual top of pg. 11</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> See the definition of an appeal from our Member Appeal Policy, the Member Handbook, and the Provider Manual.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>10. The MCE has only one level of appeal for members.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) top of pg. 9</li> <li>• Healthy Blue Provider Manual bottom of pg. 74</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b> See the Member Appeal Policy and the Provider Manual.		
<b>HSAG Findings:</b> During the compliance review, HSAG identified that LDH’s contract with the MCEs required the MCEs to maintain an informal reconsideration/peer-to-peer process. HSAG has scored this element as not applicable since state requirements differ from federal requirements. HSAG has communicated this information to LDH.		
<b>Required Actions:</b> The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
<p>11. The MCE establishes and maintains an expedited review process for appeals, when the MCE determines (for a request from the member) or the provider indicates (in making the request on the member’s behalf or supporting the member’s request) that taking the time for a standard resolution could seriously jeopardize the member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.</p> <p style="margin-left: 20px;">a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f)</p> <p>MCO Contract: 2.15.3.4.1; 2.15.4.11 PAHP Contract: 2.10.4.1; 2.10.6.12 PIHP Contract: 11.4.9.1; 11.5.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Provider materials, such as the provider manual</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 2</li> <li>Healthy Blue Member Handbook bottom of pg.80 (PDF pg. 81)</li> <li>Healthy Blue Provider Manual bottom of pg. 73</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy and the Provider Manual for an overview of the expedited appeal process.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



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Requirement	Supporting Documentation	Score
<p>12. Following receipt of a notification of an ABD by an MCE, the member has 60 calendar days from the date on the ABD notice in which to file a request for an appeal to the MCE.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1)</p> <p>MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking mechanisms</li> <li>Member materials, such as the member handbook</li> <li>ABD notice template</li> <li>Provider materials, such as the provider manual</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 3</li> <li>LA Appeal Timely Filing Tracking</li> <li>Healthy Blue Member Handbook bottom of pg.79 (PDF pg. 80)</li> <li>LA ABD Notice Letter top of pg. 2</li> <li>Healthy Blue Provider Manual middle of pg. 73</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> See the Member Appeal Policy, Member Handbook and the Provider Manual. The Appeals staff, when initially reviewing an appeal, checks to make sure this time frame is satisfied before reviewing an appeal</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>13. The member may file an appeal orally or in writing.</p> <p style="padding-left: 20px;">a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.402(c)(1)(ii) 42 CFR §438.402(c)(3)(ii)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Member consent form template</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p style="text-align: right; margin: 0;">42 CFR §457.1260(b)(1) 42 CFR §457.1260(b)(3)</p> <p>MCO Contract: 2.15.1.11; 2.15.3.1.1 PAHP Contract: 2.10.1.11; 2.10.3.1.1 PIHP Contract: 11.3.6.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 3</li> <li>Healthy Blue Member Handbook bottom of pg.79</li> <li>Appeal and Consent Request Form</li> </ul>	
<p><b>MCE Description of Process:</b> See the Member Appeal Policy and Member Handbook for the statement that a member may authorize other to appeal on their behalf. Also see the consent form.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Handling of Appeals		
<p>14. If the MCE denies a request for expedited resolution of an appeal, it:</p> <ol style="list-style-type: none"> <li>a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).</li> <li>b. Follows the requirements in 42 CFR §438.408(c)(2), including:               <ol style="list-style-type: none"> <li>i. Makes reasonable efforts to give the member prompt oral notice of the delay.</li> <li>ii. Within two calendar days, gives the member written notice of the reason for the decision to deny the expedited appeal resolution timeframe and informs the member of the right to file a grievance if the member disagrees with that decision.</li> </ol> </li> </ol> <p style="text-align: right; margin: 0;">42 CFR §438.228 42 CFR §438.408(b)(2) 42 CFR §438.408(c)(2)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Denied expedited resolution letter template</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 4</li> <li>Member Expedited Appeal Not Indicated Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.410(c) 42 CFR §457.1260(f)</p> <p>MCO Contract: 2.15.3.4.4; 2.15.3.4.5 PAHP Contract: 2.10.4.4; 2.10.4.5 PIHP Contract: 11.4.9.1.1.1; 11.4.9.1.1.2; 11.4.9.2</p>		
<p><b>MCE Description of Process:</b> See the Member Appeal Policy for a description of the process and the appeal expedited not indicated (downgrade) letter.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>15. The MCE acknowledges receipt of each appeal.</p> <p>MCO and PAHP:</p> <p>a. <i>The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each appeal unless the enrollee requests an expedited resolution.</i></p> <p>PIHP:</p> <p>a. <i>Acknowledge receipt of each grievance and appeal in writing within three (3) business days, except in instances where the resolution of the grievance occurs on the same day the grievance is received. Although the requirement to acknowledge the grievance in writing is waived in this instance, the grievance must be reported on the grievance log.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Appeal acknowledgment template</li> <li>• Tracking and reporting mechanisms</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) bottom of pg. 4</li> <li>• Member Appeal Ack Letter</li> <li>• Member Appeal Ack Tracking</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> See the Member Appeal Policy and the appeal acknowledgement letter for the time frame. Screenshot provided shows the appeal dashboard tracking system.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>16. The MCE ensures that the individuals who made decisions on appeals are individuals:</p> <ul style="list-style-type: none"> <li>a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.</li> <li>b. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease:               <ul style="list-style-type: none"> <li>i. An appeal of a denial that is based on lack of medical necessity.</li> <li>ii. An appeal that involves clinical issues.</li> </ul> </li> <li>c. Who take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial ABD.</li> </ul> <p style="text-align: right; margin-right: 50px;">           42 CFR §438.228            42 CFR §438.406(b)(2)            42 CFR §457.1260(d)         </p> <p>MCO Contract: 2.15.1.3            PAHP Contract: 2.10.1.3            PIHP Contract: 11.4.1.1.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Organizational chart of appeal staff members, including credentials</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) bottom of pg. 11 and top of pg. 12</li> <li>• LA Appeal Org Chart</li> </ul>	<p> <input type="checkbox"/> Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> NA         </p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The appeal team is a separate unit that has no input on an original decision. See the Member Appeal Policy for a description of how appeals are reviewed by others not involved in the initial determination and by those with appropriate expertise. Organizational chart showing appeals team and leadership.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The policy submitted showed that the same decision-maker may be used for appeals. During the virtual review, HBL staff confirmed that if there is a procedural error or quick resolution with an appeal, then the same person approves the appeal.</p>		
<p><b>Required Actions:</b> The MCE must revise and implement its policy to adhere with the federal requirement that the individual making decisions on appeals not be involved in any previous level of review or decision making.</p>		
<p>17. The MCE treats oral inquiries seeking to appeal an ABD as appeals.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d)</p> <p>MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) bottom of pg. 3</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> See the Member Appeal Policy allowing for verbal appeals.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>18. The MCE provides the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.</p> <p>a. The MCE informs the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member communications, such as ABD notice template, member acknowledgment template, and/or call script</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>CFR §438.408(b) and (c) in the case of expedited resolution.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.3.1.4; 2.15.3.4.3 PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 1</li> <li>Member Appeal Ack Letter</li> </ul>	
<p><b>MCE Description of Process:</b> See the Member Appeal Policy and the member appeal ack letter.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD.</p> <p>a. This information is provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).</p> <p>MCO and PAHP:</p> <p>a. <i>Upon request, the MCO/PAHP shall provide the enrollee and his or her authorized representative the enrollee's record, including all medical records and any other documents and records considered or relied upon by the MCO/PAHP regarding an appeal or state fair hearing, including the opportunity before and during the appeal or state fair hearing process for the</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member communications, such as ABD notice template, member acknowledgment template, and/or call script</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 1</li> <li>Member Appeal Ack Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><i>enrollee or an authorized Representative to examine the record. The MCO/PAHP shall provide such records free of charge and within seven (7) calendar days of receipt of the request.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3</p>		
<p><b>MCE Description of Process:</b> See the Member Appeal Policy for information that may be provided to the member or authorized representative free of charge.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Resolution and Notification of Appeals		
<p>20. The MCE resolves standard appeals and sends notice to the affected parties as expeditiously as the member’s health condition requires, but no later than 30 calendar days from the day the MCE receives the appeal.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking documentation</li> <li>HSAG will use the Universe File to evaluate timeliness</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 3</li> <li>LA 010 August 2024 Monthly Appeal Report column S</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b> See the Member Appeal Policy for the timeframe for standard appeals and the monthly report template showing timely standard resolutions.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms</li> <li>HSAG will use the Universe File to evaluate timeliness</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 14</li> <li>LA 010 August 2024 Monthly Appeal Report column O</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy for the timeframe for expedited appeals and the monthly report template showing timely expedited resolutions.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member requests the extension; or</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Requirement	Supporting Documentation	Score
<p>b. The MCE shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the member’s interest.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(e)(1) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4</p>	<ul style="list-style-type: none"> <li>Two examples of appeals with extended time frame with LDH approval</li> <li>HSAG will use the Universe File to evaluate timeliness</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 14</li> <li>LA 010 August 2024 Monthly Appeal Report column O</li> </ul>	<input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> See the Member Appeal Policy that allows for extensions of up to fourteen (14) calendar days and the monthly report that would show any extension requests. There were no extensions reported.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>23. If the MCE extends the standard or expedited appeal resolution timeframes not at the request of the member, it completes all of the following:</p> <p>a. Makes reasonable efforts to give the member prompt oral notice of the delay.</p> <p>b. Within two calendar days gives the member written notice of the reason for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with that decision.</p> <p>c. Resolves the appeal as expeditiously as the member’s health condition requires and no later than the date the extension expires.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Two examples of appeals with extended time frame with oral and written notice</li> <li>Appeal extension template letter</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 14</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2)</p> <p>MCO Contract: 2.15.3.5.2 PAHP Contract: 2.10.2.5; 2.10.2.5.3 PIHP Contract: 11.4.8.4.2</p>	<ul style="list-style-type: none"> <li>Member Appeal Extension Letter</li> <li>LA 010 August 2024 Monthly Appeal Report column S</li> </ul>	
<p><b>MCE Description of Process:</b> See the Member Appeal Policy, the examples and Member Appeal Time Frame Extended Letter Template. There were no extensions reported.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>24. In the case that the MCE fails to adhere to the appeal notice and timing requirements, the member is deemed to have exhausted the MCE’s appeals process. The member may initiate a State fair hearing (SFH).</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.8.4.3.1</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking and reporting mechanisms</li> <li>Member materials, such as the member handbook</li> <li>Appeal notice template for untimely appeal resolution</li> <li>HSAG will use the Universe File to evaluate timeliness</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 4</li> <li>LA 010 August 2024 Monthly Appeal Report column S</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The Member Appeal Policy describes this process and the monthly report that would reflect if any cases failed to adhere to the timing requirements. There were no untimely cases, and Healthy Blue does not have a separate letter for an untimely appeal.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>25. For all appeals, the MCE provides written notice of the appeal resolution that includes:</p> <ol style="list-style-type: none"> <li>a. The results of the resolution process and the date it was completed.</li> <li>b. For appeals not resolved wholly in favor of the member:               <ol style="list-style-type: none"> <li>i. The right to request a SFH, and how to do so.</li> <li>ii. The right to request and receive benefits while the hearing is pending, and how to make the request.</li> <li>iii. That the member may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCE's ABD related to the appeal.</li> </ol> </li> </ol> <p>MCO:</p> <ol style="list-style-type: none"> <li>a. <i>The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.</i></li> <li>b. <i>The MCO shall include on the notice a unique identifying number, corresponding to the number on the notice of ABD that gave rise to the appeal.</i></li> <li>c. <i>For Appeals not resolved wholly in favor of the enrollees, the notice shall include all information required under 42 CFR 438.408, including, but not limited to, informing the enrollee of their right to seek</i></li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Appeal resolution notice template</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) middle of pg. 12 and top of pg. 15</li> <li>• Member Administrative Appeal Uphold Letter</li> <li>• Member Appeal Upheld Letter</li> <li>• Member Appeal Partial Letter</li> <li>• Member Appeal Overturn Letter</li> <li>• State Fair Hearing Enclosure</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• State Approval for Overturn Letter</li> <li>• State Approval for Partial Overturn Letter</li> <li>• State Approval for Upheld Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><i>a State Fair Hearing if the enrollee is not satisfied with the MCO’s decision in response to an appeal, and the process for doing so.</i></p> <p>PAHP:</p> <ul style="list-style-type: none"> <li>a. <i>The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.</i></li> <li>b. <i>The PAHP shall include on the notice a unique identifying number, corresponding to the number on the notice of adverse benefit determination that gave rise to the appeal.</i></li> <li>c. <i>The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied with the PAHP’s decision in response to an appeal, and the process for doing so.</i></li> </ul> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(d)(2)(i) 42 CFR §438.408(e)(1-2) 42 CFR §457.1260(e)(1) 42 CFR §457.1260(e)(4)</p> <p>MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13</p>		
<p><b>MCE Description of Process:</b> See the Member Appeal Policy for a description of these requirements, and Member Appeal Resolution Letter Templates.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<p>26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice.</p> <p>MCO and PAHP:</p> <p>a. <i>In the case of an expedited appeal denial, the MCO/PAHP shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two (2) calendar days of the disposition.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1)</p> <p>MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5 PIHP Contract: 11.4.13.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use the results of the Appeals File Review</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) middle of pg. 4 and middle of pg. 10</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy showing efforts to provide oral notice of an expedited appeal.		
<b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The policy submitted did not include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution. During the virtual review, HBL staff confirmed it adheres to this requirement in practice.		
<b>Required Actions:</b> The MCE must revise its policy to include that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution.		
State Fair Hearings and State External Review		
<p>27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal.</p> <p>a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Appeal resolution notice template</li> <li>• Member materials, such as the member handbook and/or ABD notice</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p style="text-align: right; margin: 0;">42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03</p> <p>MCO Contract: 2.15.1.11; 2.15.4.1 PAHP Contract: 2.10.2.11; 2.10.6.1 PIHP Contract: 11.3.4.2; 11.4.14.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 15 and middle of pg. 3</li> <li>Member Appeal Upheld Letter</li> <li>Member Appeal Partial Letter</li> <li>Healthy Blue Member Handbook top of pg.82 (PDF pg. 83)</li> </ul>	
<p><b>MCE Description of Process:</b> See the Member Appeal Policy, Appeal Resolution Letter Templates and the member handbook.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>28. The member has <i>120 calendar days</i> from the date of the MCE’s notice of appeal resolution to request an SFH.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>An enrollee or other party to the appeal, who has completed the MCO’s appeal procedure, may request a State Fair Hearing within one hundred twenty (120) Calendar Days after receiving a notice of appeal resolution indicating that the MCO is upholding, in whole or in part, the ABD, or after the MCO fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p>PAHP:</p> <p style="margin-left: 20px;">a. <i>An enrollee or authorized representative, who has completed the PAHP’s appeal process, may request a state fair hearing within one hundred twenty (120) calendar days after receiving a notice of appeal resolution indicating that the PAHP is upholding, in</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Appeal resolution notice template</li> <li>Member materials, such as the member handbook and/or ABD notice</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 8 and top of pg. 9</li> <li>Healthy Blue Member Handbook top of pg.82 (PDF pg. 83)</li> <li>Member Appeal Upheld Letter</li> <li>Member Appeal Partial Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p><i>whole or in part, the adverse benefit determination, or after the PAHP fails to adhere to the notice and timing requirements applicable to appeals.</i></p> <p><b>PIHP:</b></p> <p>a. <i>The member may request a State Fair Hearing only after receiving notice that the PIHP is upholding the adverse benefit determination. The member may request a State Fair Hearing within one hundred and twenty (120) calendar days from the date of the PIHP’s notice of resolution.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5)</p> <p>MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2</p>		
<b>MCE Description of Process:</b> See the Member Appeal Policy, Appeal Resolution Letter Template and the member handbook.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Continuation of Benefits		
<p>29. The MCE continues the member’s benefits if all of the following occur:</p> <p>a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>ABD notice template</li> <li>Appeal resolution notice template</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The appeal involves the termination, suspension, or reduction of previously authorized services.</p> <p>c. The services were ordered by an authorized provider.</p> <p>d. The period covered by the original authorization has not expired.</p> <p>e. The member timely files for continuation of benefits.</p> <p>MCO/PAHP/PIHP:</p> <p>a. <i>Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.</i></p> <p><i>Timely files</i> means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE’s proposed ABD.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.228 42 CFR §438.420(a-b)</p> <p>MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 13</li> <li>LA ABD Notice Letter top of pg.3</li> <li>LA Member State Fair Hearing and Continuation of Benefits Form pg. 5</li> </ul>	
<b>MCE Description of Process:</b> See the Member Appeal Policy and the ABD notice letter.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>30. If, at the member’s request, the MCE continues or reinstates the member’s benefits while the appeal or SFH is pending, the benefits must be continued until one of following occurs:</p> <p>a. The member withdraws the appeal or request for SFH.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>ABD notice template</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>b. The member fails to request a SFH and continuation of benefits within 10 calendar days after the MCE sends the notice of an adverse resolution to the member’s appeal.</p> <p>c. A SFH office issues a hearing decision adverse to the member.</p> <p>MCO and PAHP:</p> <p>a. Appeals</p> <p style="padding-left: 20px;">i. <i>The time period or service limits of a previously authorized service has been met.</i></p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(c)</p> <p>MCO Contract: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 13</li> <li>LA ABD Notice Letter top of pg.3</li> </ul>	
<p><b>MCE Description of Process:</b> See the Member Appeal Policy and ABD Notice for information on the process.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>31. If the final resolution of the appeal or SFH is adverse to the member, that is, upholds the MCE’s ABD, the MCE may, consistent with the state's usual policy on recoveries under 42 CFR §431.230(b) and as specified in the MCE’s contract, recover the cost of services furnished to the member while the appeal and SFH was pending, to the extent that they were furnished solely because of the requirements under 42 CFR §438.420.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.420(d)</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>ABD notice template</li> <li>Appeal resolution notice template</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 13</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	<ul style="list-style-type: none"> <li>LA ABD Notice Letter middle of pg.3</li> <li>LA Member State Fair Hearing and Continuation of Benefits Form top of pg. 1</li> </ul>	
<b>MCE Description of Process:</b> See the Member Appeal Policy, ABD Notice and State Fair Hearing form for information on the process.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.  <div style="text-align: right; margin-right: 50px;">             42 CFR §438.228              42 CFR §438.424(b)           </div> MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Staff training materials</li> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 14</li> <li>LA High Level State Fair Hearing Workflow</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy and the State Fair hearing workflow on process.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Reinstatement of Services		
33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Tracking mechanisms</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p>disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i)</p> <p>MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1</p>	<ul style="list-style-type: none"> <li>HSAG will also use the results of the Appeals File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 14</li> <li>LA 010 August 2024 Monthly State Fair Hearing Report column I</li> </ul>	<input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy and the monthly report showing tracking of State Fair Hearing reversals.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Grievances, Appeals, and State Fair Hearings		
<p>34. In handling grievances and appeals, the MCE gives members any reasonable assistance in completing forms and taking other procedural steps related to a grievance. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d)</p> <p>MCO Contract: 2.13.15.5; 2.15.1.5 PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5 PIHP Contract: 11.4.1.1.2</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Member materials, such as the member handbook</li> <li>Example of assistance to members on filing a grievance</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 9</li> <li>Member Complaints and Grievances Policy – LA middle of pg. 4</li> <li>Healthy Blue Member Handbook bottom of pg.78 and bottom pg. of 79</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> See the Member Grievance and Appeals Policies and the Member Handbook showing reasonable assistance and the aids available to assist members in filing a grievance and appeal. The National Call Center and the translation line assist members with calls.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>35. The MCE provides written notice of the grievance and appeal resolution in a format and language that, at a minimum, meets the requirements in accordance with 42 CFR §438.10.</p> <p style="text-align: right; margin-right: 100px;">           42 CFR §438.10            42 CFR §438.228            42 CFR §438.408(d)(1)            42 CFR §438.408(d)(2)(i)            42 CFR §457.1260(e)(1)         </p> <p>MCO Contract: 2.13.15.5; 2.15.1.5            PAHP Contract: 2.9.2.1.3.2.4; 2.10.1.5            PIHP Contract: 5.15.2; 5.15.3</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Mechanisms to assess reading grade level of member notices</li> <li>Grievance and appeal resolution templates, including taglines</li> <li>HSAG will also use the results of the Grievances and Appeals File Reviews</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) bottom of pg. 12 and top of pg. 13</li> <li>Member Complaints and Grievances Policy – LA top of pg.1</li> <li>Grade Level Assessment Tool</li> <li>Member Grievance Resolution Letter</li> <li>Member Appeal Upheld Letter</li> <li>Member Appeal Partial Letter</li> <li>Member Appeal Overturn Letter</li> <li>Member Administrative Appeal Uphold Letter</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Appeal file cases 1-10 RGL</li> <li>Grievance file cases 1-10 RGL</li> </ul>	
<b>MCE Description of Process:</b> See the Member Grievance and Appeal Policies and the Appeal and Grievance Resolution Letters.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>36. The MCE provides information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g)</p> <p>MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1</p>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Provider manual</li> <li>Provider contract</li> <li>Subcontractor agreement template</li> </ul> <hr/> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) top of pg. 9</li> <li>Member Complaints and Grievances Policy – LA top of pg.5</li> <li>Standard XIII.36_Healthy Blue Provider Manual_2023.pdf (Pgs. 11, 72-73)</li> <li>Standard XIII.36_Provider Contract Example.pdf (Pgs. 25, 34)</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeals Policy. The MCE ensures compliance with the requirement of 42 CFR §438.10(g)(2)(xi) by providing comprehensive details about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract. The "Provider Manual" serves as a crucial resource, specifically on pages 11 and 72-73, which outline the procedural aspects and contacts necessary for addressing grievances and appeals, thereby ensuring that providers have clear guidance on navigating these processes. Additionally, the "Provider Contract Example," particularly on pages		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
25 and 34, includes explicit clauses and terms detailing the obligations and rights related to grievances and appeals, effectively integrating compliance into the contractual agreement.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
37. The MCE includes as parties to the appeal and SFH: <ol style="list-style-type: none"> <li>a. The member and his or her representative.</li> <li>b. The legal representative of a deceased member’s estate.</li> <li>c. For SFH, the MCE.</li> </ol> <div style="text-align: right; margin-top: 10px;">             42 CFR §438.228              42 CFR §438.406(b)(6)              42 CFR §438.408(f)(3)              42 CFR §457.1260(e)(5)           </div> <div style="margin-top: 10px;">             MCO Contract: 2.15.3.1.6              PAHP Contract: 2.10.3.1.5              PIHP Contract: 11.4.2.4.2; 11.4.14.5           </div>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Member materials, such as the member handbook and/or notice templates</li> </ul> <hr/> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• Member Appeals – Core Process (Physical Health) top of pg. 9</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> See the Member Appeal Policy.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Recordkeeping Requirements		
38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: <ol style="list-style-type: none"> <li>a. A general description of the reason for the appeal or grievance.</li> </ol>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

<b>Standard XIII—Grievance and Appeal Systems</b>		
<b>Requirement</b>	<b>Supporting Documentation</b>	<b>Score</b>
<p>b. The date received.</p> <p>c. The date of each review or, if applicable, review meeting.</p> <p>d. Resolution at each level of the appeal or grievance, if applicable.</p> <p>e. Date of resolution at each level, if applicable.</p> <p>f. Name of the member for whom the appeal or grievance was filed.</p> <p>PIHP:</p> <p>a. Medicaid number</p> <p>b. Summary of grievances and appeals;</p> <p>c. Current status;</p> <p>d. Resolution with date of resolution and resulting corrective action;</p> <p>e. The total number of grievances, appeals and State Fair Hearings held for the reporting period broken out by members and providers filing on behalf of members;</p> <p>f. The status and resolution of all claims disputes;</p> <p>g. Trends and types of grievances and appeals;</p> <p>h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and</p> <p>i. The number of State Fair Hearings and resolution during the reporting period.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h)</p> <p>MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Member Appeals – Core Process (Physical Health) middle of pg. 10 and top of pg. 12</li> <li>Member Complaints and Grievances Policy – LA middle of pg. 5</li> </ul>	



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<b>MCE Description of Process:</b> See the Member Grievance and Appeal Policies for recordkeeping requirements.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		

Results for Standard XIII—Grievance and Appeal Systems							
<b>Total</b>	Met	=	32	X	1	=	32
	Not Met	=	5	X	0	=	0
	Not Applicable	=	1				
<b>Total Applicable</b>		=	37	<b>Total Score</b>		=	32

<b>Total Score ÷ Total Applicable</b>	=	<b>86%</b>
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**Louisiana Department of Health  
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**Standard XIV—Program Integrity**

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Certification</b>		
<p>1. Documentation or information the MCE submits to LDH is certified by the MCE’s Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.</p> <p>a. The certification provided by the individual must attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in §438.604 is accurate, complete, and truthful.</p> <p>b. The MCE submits the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).</p> <p style="text-align: right;">42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o)</p> <p>MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures to certify the data specified in 42 CFR §438.604</li> <li>• Position and job description of individual responsible for certification</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 01_Systems Quality Assurance Plan - Encounter Data - LA_Policy and Procedure document. (page 2 and 4)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Certification Follow-up Evidence</li> <li>• Systems Quality Assurance Plan - Encounter Data</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> All encounter submissions are certified in compliance with established protocols. The submissions analyst validates the data counts loaded into the Encounter System, the counts submitted in the files, and any pending records for each submission batch, covering both medical and vendor data. Before each submission, the encounter’s team receive approval from the Health Plan’s Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an authorized delegate who reports directly to them.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Required Actions:</b> No action required.		
Compliance Program/Program Integrity Plan		
<p>2. The MCE develops a compliance program that includes:</p> <ol style="list-style-type: none"> <li>a. Written policies, procedures, and standards of conduct that articulate the MCE or subcontractor’s commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and State requirements.</li> <li>b. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Chief Executive Officer and the board of directors.</li> <li>c. The establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization’s compliance program and its compliance with the requirements under the Contract.</li> <li>d. A system for training and education for the Compliance Officer, the organization’s senior management, and the organization’s employees, for the Federal and State standards and requirements under the Contract.</li> </ol> <p>MCO and PAHP:</p> <ol style="list-style-type: none"> <li>a. <i>Fraud, waste, and abuse training shall include, but not be limited to:</i> <ol style="list-style-type: none"> <li>i. <i>Annual training of all employees; and</i></li> </ol> </li> </ol>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Program Integrity Compliance Plan</li> <li>• Program Integrity (PI) Annual Work Plan</li> <li>• Compliance Officer job description</li> <li>• Organizational chart</li> <li>• Regulatory Compliance Committee charter</li> <li>• Compliance training plan</li> <li>• Compliance training materials</li> <li>• Training tracking mechanisms</li> <li>• Communication protocol for Compliance issues (e.g., hotline)</li> <li>• Code of Ethics</li> <li>• HSAG will also use findings from the Compliance Reporting/Tracking system demonstration</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2-08. 12-13, 18 ElevanceHealth_SIU Antifraud Plan.pdf, Pgs. A9, 14-23</li> <li>• 2, 12-13 2024 Do The Right Thing Script entire document</li> <li>• 2, 12-13 2024 Do The Right Thing Certification Module.pdf, entire document</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>ii. <i>New hire training within thirty (30) Calendar Days of beginning date of employment.</i></p> <p>b. <i>The MCO/PAHP shall require new employees to complete and attest to training modules within thirty (30) calendar days of hire related to the following in accordance with applicable Federal and State laws, regulations, rules, and policies:</i></p> <p>i. <i>MCO/PAHP Code of Conduct Training;</i></p> <p>ii. <i>Privacy and Security - Health Insurance Portability and Accountability Act;</i></p> <p>iii. <i>Fraud, Waste, and Abuse identification and reporting procedures;</i></p> <p>iv. <i>The False Claims Act and employee whistleblower protections;</i></p> <p>v. <i>Procedures for Timely consistent exchange of information and collaboration with LDH;</i></p> <p>vi. <i>Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and</i></p> <p>vii. <i>Provisions that comply with 42 CFR §438.608 and §438.610 and all relevant State and Federal laws, regulations, policies, procedures, and guidance (including CMS' Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks) issued by LDH, HHS, CMS, and OIG, including updates and amendments to these documents or any such standards established or adopted by the State of Louisiana or its agencies.</i></p>	<ul style="list-style-type: none"> <li>• 2, 12-13 Louisiana Medicaid SIU Training Roster_CY2024, entire document</li> <li>• 2_20241231_LA Medicaid SIU Organizational Chart.pdf, entire document</li> </ul> <p>Compliance Training Plan –</p> <ul style="list-style-type: none"> <li>• 2_2024 Ethics, Compliance, Privacy Compliance plan pgs. 9-10</li> <li>• Compliance officer job description - 2_Medicaid Compliance Officer (entire document)</li> </ul> <p>Tracking Mechanisms –</p> <ul style="list-style-type: none"> <li>• 2_2024 Ethics, Compliance, Privacy Compliance plan pgs.10-11</li> </ul> <p>Communication Protocol –</p> <ul style="list-style-type: none"> <li>• 2_2024 Ethics, Compliance, Privacy Compliance plan pgs.12-13</li> <li>• 2a-d_2024 Ethics, Compliance Privacy Compliance plan</li> </ul> <p>Communication Protocol</p> <ul style="list-style-type: none"> <li>• 02, 05, 12 2024 Code of Conduct pg. 6</li> <li>• 02, 05, 12_2024 Elevance Health Code of Conduct (Entire Document)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• New Associate Ethics, Compliance and Privacy Training Program</li> </ul>	



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>c. <i>Effective lines of communication between the compliance officer and the organization’s employees.</i></p> <p>d. <i>Enforcement of standards through well-publicized disciplinary guidelines.</i></p> <p>e. <i>Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract.</i></p> <p><b>PIHP:</b></p> <p>a. <i>Provisions for the confidential reporting of plan violations, such as a hotline to report violations and a clearly designated individual, such as the Program Integrity 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;</i></p> <p>b. <i>A description of the methodology and standard operating procedures used to identify and investigate fraud and abuse, and to recover overpayments or otherwise sanction providers;</i></p> <p>c. <i>Procedures for timely and consistent exchange of information and collaboration with LDH Program Integrity, LDH-OBH, the Louisiana Attorney General,</i></p>	<ul style="list-style-type: none"> <li>• New Associate Ethics, Compliance and Privacy Training page 2</li> <li>• 2024_DTRT_EH_MasterResources</li> <li>• PI Organizational Chart</li> <li>• Annual and Ongoing Ethics, Compliance and Privacy Training pages 2 and 4</li> </ul>	



**Louisiana Department of Health  
2025 Compliance Review for Healthy Blue**

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;</i></p> <p>d. <i>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; and</i></p> <p>e. <i>Protections to ensure that no individual who reports program integrity related violations or suspected fraud and/or abuse is retaliated against by anyone who is employed by or contracts with the PIHP. The PIHP shall ensure that the identity of individuals reporting violations of the compliance plan shall be held confidentially to the extent possible.</i></p> <p style="text-align: right;">42 CFR §438.608(a)(1)</p> <p>MCO Contract: 2.20.2.2.1; 2.20.2.2.2; 2.20.2.2.3; 2.20.2.2.4; 2.20.2.2.5; 2.20.2.2.6; 2.20.2.2.7</p> <p>PAHP Contract: 2.12.5.2.1; 2.12.5.2.2; 2.12.5.2.3; 2.12.5.2.4; 2.12.5.2.5; 2.12.5.2.6; 2.12.5.2.7; 2.12.5.2.8; 2.12.5.2.9</p> <p>PIHP Contract: 13.1.2.3.1; 13.1.2.3.2; 13.1.2.3.4; 13.1.2.3.5; 13.1.2.3.6; 13.1.2.3.7; 13.1.2.3.8; 13.1.2.3.9; 13.1.2.3.10; 13.1.2.3.11</p>		
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "Elevance Health SIU Antifraud Plan.pdf" outlines a comprehensive training and education system to ensure compliance with federal and state standards across all organizational levels, including the Compliance Officer, senior management, and employees. It mandates annual and role-specific training sessions covering essential topics like the Code of Conduct, Fraud, Waste, and Abuse (FWA) prevention, HIPAA privacy and security, and procedures for identifying and reporting FWA. New employees must complete required training within thirty days, which includes the False Claims Act and whistleblower protections, informing them of their legal rights and responsibilities. The plan meets requirements of 42 CFR §438.608 and §438.610, aligning with CMS guidelines and mandates from agencies such as LDH and HHS. Through</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>structured training and clear compliance measures, the document demonstrates Elevance Health's commitment to upholding legal and ethical standards, adhering to contractual obligations, and fostering an organizational culture of integrity and accountability.</p> <ul style="list-style-type: none"> <li>○ The "2024 Do The Right Thing Script.pdf" outlines a structured training program for employees, emphasizing compliance with federal and state standards and aligning with contract requirements for organizational compliance training. The framework includes tailored modules on ethics, regulations, and fraud prevention, with new employees required to complete mandatory training within thirty days. Key areas covered include the MCO/PAHP Code of Conduct, HIPAA compliance, fraud prevention, and whistleblower protections. The program aligns with 42 CFR §438.608 by cultivating a culture that supports reporting misconduct without fear of retaliation and complies with 42 CFR §438.610 by mandating cooperation with investigations and secure handling of confidential information. Overall, the document underscores the importance of ethics and compliance, incorporating privacy by design, secure data practices, and clear reporting protocols to ensure comprehensive education and accountability.</li> <li>○ The "2024 Do The Right Thing Certifications Module.pdf" outlines the certifications that employees are required to complete as part of the training detailed in the "2024 Do The Right Thing Script.pdf." These certifications ensure that employees are well-versed in ethics, compliance, privacy, and information security within their roles, adhering to Elevance Health's standards for protecting confidential information and maintaining overall organizational integrity. All employees complete this training annually and new employees take this training where there also attest to the Code of Conduct</li> <li>○ The "Louisiana Medicaid SIU_Training Roster_CY2024" displays all SIU Associates that supports (or) supported Medicaid for the state of Louisiana during the audit timeframe and their Do the Right Thing Training and all other annual training completion.</li> <li>○ The "20241231_LA Medicaid SIU Organizational Chart.pdf" provides a detailed overview of the dedicated staff within the Special Investigations Unit (SIU) responsible for overseeing compliance and fraud-related issues. The chart illustrates the roles contributing to the routine internal monitoring and auditing of compliance risks. It highlights specific positions tasked with addressing compliance issues swiftly and coordinating investigations into potential problems. This structure supports a prompt response to compliance concerns, the thorough investigation of identified issues, and, when necessary, coordination with law enforcement for suspected criminal activities, and maintains ongoing compliance with contractual requirements.</li> <li>○ The 2024 Ethics, Compliance, and Privacy Compliance Plan emphasizes communication protocols and tracking mechanisms. Additionally, the policies and procedures (P&amp;P) for the Medicaid Compliance Officer delineate the roles and responsibilities of all Plan Compliance Officers. Moreover, the 2024 Code of Ethics is distributed annually to all associates, including new hires. Associates acknowledge their understanding and commitment to following the Code of Ethics through the "Do the Right Thing" training program.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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<p>3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP:</p> <p style="margin-left: 20px;">a. <i>The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.</i></p> <p>MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Program Integrity Compliance Plan</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2024_National_Program_Integrity_Plan pdf, Pgs. 4-9</li> <li>02-08. 12-13, 18 ElevanceHealth_SIU Antifraud_Plan.pdf, Pgs. A11, 38-40</li> <li>03, 04, 13 Investigations of Suspected Fraud and Abuse.pdf, entire document</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth SIU Antifraud Plan.pdf" details procedures for responding promptly to detected fraud, waste, and abuse (FWA) offenses, fulfilling contractual obligations through a structured investigative approach. It employs claims data analysis as a primary method to identify potential FWA, with investigations that can lead to various corrective actions. When inappropriate billing is observed, corrective actions ensue to prevent future issues. The document also emphasizes ongoing monitoring and detailed documentation for comprehensive case management, ensuring thorough addressing of compliance issues as they arise. Overall, the plan demonstrates compliance by outlining a proactive and detailed framework for handling FWA, aligned with federal and state regulations.</li> <li>○ The "Investigations of Suspected Fraud and Abuse.pdf" document outlines the Special Investigations Unit's (SIU) comprehensive procedures for addressing suspected fraud and abuse. It emphasizes a structured approach to promptly respond to detected offenses and implement corrective actions, which are essential for maintaining compliance with contractual obligations. The document details the process for identifying and investigating suspected fraud, waste, and abuse (FWA) through various methods such as claims data mining, fraud hotline complaints, and referrals. The document describes specific corrective actions, including sending warning letters, placing providers on prepayment review, suspending or terminating providers, and seeking recovery of funds. These steps ensure that offenses are addressed swiftly, and corrective measures are enforced to uphold the integrity of the healthcare program and comply with contractual and regulatory standards.</li> <li>○ The 2024 National Program Integrity Plan outlines the different facets that provide value to Program Integrity's detection of potential fraud, waste, and abuse that are essential for fulfilling contractual and regulatory standards. These facets are regarded as pillars that are essential for the end-to-end function of the PI program, and lead to the commitment to detecting, correcting, and preventing FWA in its operations</li> </ul>		



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<p>consistent with applicable laws, regulations, and guidance. Elevance Health PI Organization has an effective program in place to proactively and reactively identify and investigate suspected fraud, waste and abuse and to proactively help prevent payment of fraudulent, wasteful, or abusive claims. Elevance Health takes a comprehensive approach to combat fraud, waste, and abuse</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>4. Additional compliance program requirements: MCO:</p> <p>a. <i>The MCO's compliance program shall incorporate the following requirements:</i></p> <p style="margin-left: 20px;">i. <i>Detection and prevention of Louisiana Medicaid Program violations and possible fraud, waste, and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.</i></p> <p style="margin-left: 20px;">ii. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, including: lists of pre-payment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.</i></p> <p style="margin-left: 20px;">iii. <i>Provisions for the confidential reporting of plan violations, such as a dedicated toll-free hotline to report violations and a clearly designated individual, such as the contract compliance officer, to receive them. Several independent reporting</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Program Integrity Compliance Plan</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2024_National_Program_Integrity_Plan_Plan.pdf, Pgs. 4-9, 21-23</li> <li>2-08. 12-13, 18 ElevanceHealth_SIU Antifraud Plan.pdf, Pgs. A12-A13, 17, 20, 23-27, 31-35, 39-43</li> <li>3, 4, 13_ Investigations of Suspected Fraud and Abuse.pdf, entire document</li> <li>4_SIU Provider Prepayment Review.pdf, entire document</li> <li>4_Hotline Overview_LA.pdf, entire document</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><i>paths shall be created for the reporting of fraud so that such reports cannot be diverted by supervisors or other personnel.</i></p> <p>iv. <i>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.</i></p> <p>PAHP:</p> <p>a. <i>Detection and prevention of Medicaid program violations and possible fraud, waste and abuse overpayments through data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques.</i></p> <p>b. <i>Descriptions of specific controls in place for prevention and detection of potential or suspected fraud, waste and abuse, including: lists of prepayment claims edits, post-payment claims edits, post-payment claims audit projects, data mining and provider profiling algorithms; and references in provider and member materials relative to identifying and reporting fraud to the plan and law enforcement.</i></p> <p>c. <i>Provisions for the confidential reporting of plan violations, such as a dedicated hotline to report violations and a clearly designated individual, such as the 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.</i></p>		



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<p>d. <i>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.</i></p> <p>e. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to enrollees, providers, PAHP employees and the public on the PAHP’s website required under the contract. The PAHP must implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i></p> <p><b>PIHP:</b></p> <p>a. <i>The PIHP’s fraud, waste and abuse policies and procedures shall provide-and certify that the PIHP’s fraud, waste and abuse unit has access to records of providers.</i></p> <p style="padding-left: 20px;">i. <i>The PIHP shall develop an approval process that demonstrates the policies and procedures were reviewed and approved by the PIHP’s senior management.</i></p> <p>b. <i>Description of effective training and education for the compliance officer, the organization’s employees, PIHP providers and members to ensure that they know and understand the provisions of the fraud, waste and abuse compliance plan and know about fraud and abuse and how to report it</i></p>		



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<p>c. <i>A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.</i></p> <p>MCO Contract: 2.20.2.3 PAHP Contract: 2.12.5.3 PIHP Contract: 13.1.2.5; 13.1.2.11; 13.1.2.12</p>		
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "Elevance Health SIU Antifraud Plan.pdf" document outlines a robust compliance program aimed at detecting and preventing Louisiana Medicaid Program violations and potential fraud, waste, and abuse. It implements data matching, trending, statistical analysis, and monitoring of service and billing patterns through advanced data mining techniques to uncover potential overpayments and fraudulent activities. Specific controls are in place, including pre-payment and post-payment claims edits, post-payment audit projects, and sophisticated data mining and provider profiling algorithms, all of which are integral to identifying and addressing possible fraudulent activities. The plan ensures confidential reporting of violations through a dedicated toll-free hotline and designated personnel, such as the contract compliance officer, providing several independent reporting paths to safeguard against report diversion. Furthermore, the document details written policies and procedures for conducting both announced and unannounced site visits and audits, reinforcing the program's commitment to ensuring services are properly rendered and billed.</li> <li>○ The "Investigations of Suspected Fraud and Abuse.pdf" outlines a comprehensive approach to detecting and preventing fraud, waste, and abuse within the healthcare system, focusing on the activities of the Special Investigations Unit (SIU). The SIU utilizes a variety of tools and techniques, including coding software, data analytics, and internal proprietary healthcare analytics to identify suspicious billing behaviors. Investigations are primarily provider-centric and involve reviewing claim submissions to ensure compliance with medical coding guidelines and federal or state regulations. To prevent unjustified payments, the SIU implements preventative measures such as prepayment reviews, especially for providers with a history of suspicious claims. This prepayment review process is conducted by a team staffed with coders and clinicians, assessing issues like upcoding and billing for services not rendered. Confidential reporting mechanisms, such as fraud hotlines, are in place to ensure that potential violations can be reported securely. Information gathered from these reports is triaged and reviewed to determine if it warrants a preliminary or full investigation. The SIU also may conduct site visits and field audits as part of its investigative procedures, ensuring services are properly rendered and billed. The document also outlines detailed reporting requirements for fraud and abuse cases, including the need to report specific details of each investigation to appropriate authorities as prescribed by the contract and regulations.</li> <li>○ The "SIU Provider Prepayment Review.pdf" document outlines the policies and procedures of the Special Investigations Unit (SIU) in examining providers suspected of Fraud and Abuse (F&amp;A). The activities detailed within the document demonstrate compliance with the</li> </ul>		



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<p>requirements set out for the prevention and detection of potential fraud, waste, and abuse in numerous ways. The SIU employs a focused approach to examining suspected providers by implementing preventative measures such as prepayment reviews. Extensive research is undertaken before placing a provider into this review program, ensuring justifications based on coding issues, such as upcoding and unbundling, are scrutinized. The Prepayment Review team, comprised of coders and clinicians, assesses claims for accuracy, placing holds on those from providers with a history of miscoding or medically unnecessary charges. The SIU runs identification methods, including coding software and proprietary analytics, for detecting anomalies in billing behaviors, further fulfilling the requirements for detecting fraud, waste, and abuse. The strategic use of the fraud hotline, complaints, claims data mining, and referrals from various sources helps in building reliable allegations which are then carefully investigated. Confidentiality in reporting is maintained through a system where fraud hotline calls are managed by the SIU. The process ensures appropriate measures are in place to prevent unauthorized diversions of fraud reports. For cases warranting preliminary investigation, comprehensive reviews are conducted to decide on the necessity of a full investigation. Overall, the detailed framework for preventing, detecting, and investigating fraudulent activities through data analysis, provider profiling, and prepayment claims evaluations demonstrate adherence to the compliance requirements effectively.</p> <ul style="list-style-type: none"> <li>○ The "Hotline Overview_LA.docx" document provides an overview of the procedures for handling the Special Investigations Unit (SIU) hotline, showcasing compliance with the requirements for preventing and detecting fraud, waste, and abuse effectively. This document describes how the SIU manages a confidential hotline system for reporting suspected fraud or abuse, ensuring anonymity and providing multiple avenues for reporting such instances. The hotline system is an integral part of creating independent reporting paths, which is crucial for preventing reports from being diverted by unauthorized personnel. Calls are recorded and funneled to a centralized system where they are evaluated, ensuring confidentiality and systematic processing. The document outlines that messages received through the hotline are promptly reviewed by a specialized team, who assess whether the information constitutes a fraud allegation. Leads are entered into a case management system exclusive to the SIU and are classified as leads, which are further investigated based on state and business line priorities. Furthermore, the document ensures that the SIU hotline process supports the detection and prevention of fraud by tracking and reviewing calls regularly, and the information gathered is used to initiate preliminary investigations. The SIU team conducts these investigations to determine if a full investigation is warranted, demonstrating a proactive approach to identifying fraudulent actions. Through these measures, the provided hotline overview aligns with, and supports, the compliance requirements for comprehensive fraud, waste, and abuse detection, prevention, and reporting.</li> <li>○ The 2024 National Program Integrity Plan outlines the tools used in preventing potential opportunities for fraud, waste, and abuse in PI's operations that are consistent with applicable laws, regulations, and guidance. These tools have helped to develop an effective program that does its job of proactively and reactively identifying, investigate, and mitigate suspected fraud, waste and abuse and to proactively help prevent payment of fraudulent, wasteful, or abusive claims.</li> </ul>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		



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<b>Required Actions:</b> No action required.		
<p>5. Publicized email address: MCO and PAHP:</p> <p>a. <i>Effective implementation of a well-publicized email address for the dedicated purpose of reporting fraud. This email address must be made available to Enrollees, providers, MCO/PAHP employees and the public on the MCO's/PAHP's website.</i></p> <p>b. <i>The MCO/PAHP shall implement procedures to review complaints filed in the fraud reporting email account at least weekly, and investigate and act on such complaints as warranted.</i></p> <p>MCO:</p> <p>a. <i>The MCO shall submit to LDH or its designee the fraud, waste, and abuse compliance plan as part of readiness review, annually thereafter, and upon updates or modifications for written approval at least thirty (30) calendar days in advance of making them effective.</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall submit the fraud and abuse compliance plan to LDH. The PAHP shall submit updates or modifications to LDH for approval at least thirty (30) calendar days in advance of the effective date. LDH, at its sole discretion, may require that the PAHP modify its compliance plan.</i></p> <p>MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Program Integrity Compliance Plan</li> <li>• Evidence of publicized email address</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2024_National_Program_Integrity Plan _Plan pdf, Pgs. 20-21, 30</li> <li>• 2-08. 12-13, 18_ElevanceHealth_SIU Antifraud Plan.pdf, Pgs. A13, 23, 41-43</li> <li>• 5_FightHealthcareFraud.com.pdf, entire document</li> <li>• 5_FightHealthcareFraud_2.pdf, entire document</li> <li>• 5_Triage_Lead_SIU_Flowchart.pdf, entire document</li> <li>• 5-08, 18_Healthy Blue Provider Manual, Pgs. 75-76</li> <li>• 5_Healthy Blue Member Handbook, Pgs. 87-91</li> <li>• 05 “Communication Protocol”</li> <li>• 2, 05, 12_2024 Elevance Code of Conduct pg. 6</li> <li>• 05 Screenshots of Provider and Member Website</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 2024 FWA Compliance Plans Due by January 30-Healthy Blue</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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	<ul style="list-style-type: none"> <li>Modifications are submitted 30 days in advance, as necessary. No modifications took place throughout 2024.</li> <li>Email of the annual submission of the 2024 FWA Compliance plan to LDH</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" document establishes a well-publicized email address dedicated to reporting fraud, making it accessible to enrollees, providers, contractor employees, and the public through the Company website. It defines procedures for reviewing complaints submitted via email ensuring prompt investigation and necessary action for unresolved issues. The document requires that the Fraud, Waste, and Abuse Compliance Plan be submitted to the Louisiana Department of Health (LDH) for approval as part of the Readiness Review. LDH holds discretion to request compliance plan modifications to maintain stringent oversight. Additionally, the document emphasizes effective communication lines between the Contract Compliance Officer and employees, ensuring seamless reporting and addressing of fraud-related issues.</li> <li>○ The "FightHealthcareFraud.com.pdf" document describes the online platform <a href="http://www.fighthealthcarefraud.com">www.fighthealthcarefraud.com</a>, which Elevance Health developed to combat healthcare fraud through consumer education and reporting. The site facilitates direct communication with the Special Investigations Unit (SIU) and provides an easy means for users to anonymously report fraud. It is also designed to educate consumers about the importance of understanding their Explanation of Benefits (EOB). Additionally, during National Fraud Awareness Week, Elevance Health promotes the site through various channels, including company intranet articles, social media, and office displays. The platform simplifies anonymous reporting and interaction details suggest an infrastructure that align with compliance requirements.</li> <li>○ The "FightHealthcareFraud_2.pdf" document consists of images demonstrating a publicized fraud reporting method dedicated to enrollees, employees, providers, and the public.</li> <li>○ The "Triage_Lead_SIU_Flowchart.pdf" document visually outlines the procedure for managing referrals and requests for information related to potential fraud within Elevance Health. This flowchart demonstrates compliance with the requirement by showcasing the steps taken once a referral is pulled from a shared email box, illustrating the effective implementation of a well-publicized email address dedicated to fraud reporting. It ensures Enrollees, providers, Contractor employees, and the public can easily access this email on the Contractor’s website for fraud reporting. The document describes a structured process where referrals are reviewed and investigated weekly, consistent with procedural obligations. Additionally, by highlighting the flow from initial receipt through manager review, conflict checks, and necessary follow-up actions, the flowchart exemplifies the required communication channels between the Contract Compliance Officer and employees, thereby supporting efficient oversight and resolution of fraud-related issues.</li> </ul>		



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<ul style="list-style-type: none"> <li>○ The "Healthy Blue Provider Manual" effectively demonstrates compliance with the requirement for a well-publicized fraud reporting system. It provides contact information for reporting fraud, including through the website <a href="http://www.fighthealthcarefraud.com">www.fighthealthcarefraud.com</a>, making it accessible to enrollees, providers, contractor employees, and the public. The manual outlines Healthy Blue's commitment to preventing, detecting, and investigating fraud, waste, and abuse with established procedures that ensure confidentiality and encourage reporting without fear of retaliation. The document emphasizes robust investigation processes. Furthermore, Healthy Blue maintains a Special Investigations Unit fraud hotline, indicating a structured approach to handling reports. The document underscores the submission of the Fraud, Waste, and Abuse Compliance Plan to LDH as part of readiness reviews and for annual updates, aligning with regulatory compliance expectations. These measures ensure that Healthy Blue meets contractual obligations for fraud reporting and management.</li> <li>○ The "Healthy Blue Member Handbook" effectively demonstrates compliance with the requirement for a well-publicized mechanism to report fraud through the mention of the website <a href="http://www.fighthealthcarefraud.com">www.fighthealthcarefraud.com</a>, which serves as a resource for educating the public on reporting fraud, waste, and abuse. This ensures accessibility for enrollees, providers, contractor employees, and the general public, aligning with the contractual obligation to make such resources available. The handbook emphasizes Healthy Blue's strong commitment to preventing, detecting, and investigating fraudulent activities. By providing multiple reporting channels, including customer service lines and a hotline, the document ensures that members and the public are actively involved in safeguarding the integrity of the Medicaid program. This emphasis on public accessibility, along with the structured approach to handling and responding to fraud reports, supports the overall compliance with the stated requirements.</li> <li>○ The Code of Ethics tells associates how they can report ethics violations via the ethics email</li> <li>○ The 2024 National Program Integrity Plan explains how SIU referrals originate from many sources, both internally and externally, and are referred to as leads. Leads are received through the mail, via the telephone, in person, email, internet, intranet, or from the Compliance hotline. They will come from enrollees, providers, employees, law enforcement agencies, and professional organizations.</li> </ul>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<b>Overpayments and Treatment of Recoveries</b>		
6. The MCE implements and maintains arrangements or procedures for the prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to LDH.	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>• Policies and procedures, including timeline for prompt reporting of overpayments</li> <li>• Special investigations unit (SIU) workflows</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p style="text-align: right; margin-right: 10px;">42 CFR §438.608(a)(2)</p> <p>MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9</p>	<ul style="list-style-type: none"> <li>Identification mechanisms</li> <li>Reporting mechanisms</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Staff training materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2024_National_Program_Integrity_Plan_Plan.pdf, Pg.14</li> <li>6_145 Report and Confirmation of Submissions</li> <li>2-8. 12-13, 18_ElevanceHealth SIU Antifraud_Plan.pdf, Pgs. A12, 34, 37, 46-47</li> <li>6-7, 13 Reporting of Fraud and Abuse Investigations.pdf, entire document</li> <li>6. 7 Overpayments.pdf, entire document</li> <li>6-8 LA PI145_FWA_Quarterly_Report Q424.xlsx, entire document</li> <li>05-08, 18 Healthy Blue Provider Manual, Pgs. 177-179</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" outlines structured procedures for the prompt reporting of overpayments to the State, specifically focusing on those due to potential fraud. The plan mandates that overpayments be reported to the Louisiana Department of Health (LDH) within 60 calendar days of identification, ensuring timely communication of financial discrepancies. It includes monthly reporting of all audits conducted, highlighting overpayments identified and recovered, which ensures a continuous update and review process for compliance purposes. The document also stresses the importance of retaining documentation for a minimum of ten years, providing a comprehensive record for accountability and future audits. Overall, the plan demonstrates compliance by establishing a clear protocol for timely reporting and maintaining transparency with state authorities regarding fraud-related financial recoveries.</li> </ul>		



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<ul style="list-style-type: none"> <li>○ The "Reporting of Fraud and Abuse Investigations.pdf" document outlines the procedures for the Special Investigations Unit (SIU) to report overpayments identified and recovered due to potential fraud. The SIU is responsible for examining providers suspected of fraud and abuse and for reporting information to state authorities as prescribed by state contracts. The document specifies that the SIU must include in their reports' details such as the provider's name and number, the nature of the complaint, the type of provider, the source of the complaint, the approximate amount of money involved, and the legal and administrative disposition of each case, including any actions taken by law enforcement. This structured reporting ensures that all overpayments due to suspected fraud are promptly communicated to the state, thereby demonstrating compliance with the established requirements for fraud and abuse prevention and resolution.</li> <li>○ The "D7, D8, E1.1_Overpayments.pdf" document outlines detailed procedures for ensuring compliance with the mandate to promptly report all overpayments, particularly those associated with potential fraud, to the State. It establishes a structured process whereby health care providers must notify Managed Care Plans (MCPs) of identified overpayments and return funds within 60 days, in accordance with the Patient Protection and Affordable Care Act (PPACA). Additionally, the document specifies that any overpayments related to potential fraud must be reported to relevant oversight bodies within 10 days. These comprehensive measures, with clear timelines and documentation requirements, demonstrate the document's commitment to regulatory compliance by ensuring all parties involved adhere to stringent notification and reporting protocols.</li> <li>○ The "LA PI145_FWA_Quarterly_Report_Q424.xlsx" document shows all cases and leads with activity during the quarter being reported. This includes cases opened in the report quarter, closed in the report quarter, or opened prior to the report quarter and remaining open. It documents all audit activities performed by the Company, reports all issues where overpayments were identified because of provider activity, and reports all recovery activity performed.</li> <li>○ The "Healthy Blue Provider Manual" outlines comprehensive procedures for the prompt reporting and handling of overpayments, which play a key role in demonstrating compliance with state requirements. It includes a strict definition of overpayment according to the False Claims Act, which must be reported within 60 days to avoid such payments being considered false claims and incurring penalties. The document specifies that healthcare providers, suppliers, and Medicaid managed care organizations are responsible for implementing consistent policies to report and return overpayments as mandated by the PPACA. It further requires Healthy Blue to notify providers in writing about overpayment recoupment intentions, providing claim details and reasons. Providers are granted 60 days to respond to such notifications, and Healthy Blue must consider these responses within 30 days and justify recoupment actions in writing. Importantly, cases involving fraud, waste, or abuse discovered beyond the standard one-year timeframe for reviews are subject to different processes, ensuring that potential fraud-related overpayments are addressed effectively. This structured procedure ensures that all identified and recovered overpayments, including those due to potential fraud, are reported to the state promptly and managed in compliance with relevant legislation and regulatory requirements.</li> </ul>		



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<ul style="list-style-type: none"> <li>○ The 2024 National Program Integrity Plan explains how recovery operations partner with providers, Network Management, and Legal to optimize collection of overpayments. This department within CPI manages disputes, correspondence, and inquiries by providing customer support and resolution. They are also responsible for updating claims systems to reflect solicited and unsolicited cash received.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>7. The MCE follows the retention policies for the treatment of recoveries of all overpayments from the MCE to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.</p> <ul style="list-style-type: none"> <li>a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments.</li> <li>b. The MCE complies with the process, timeframes, and documentation LDH requires for payment of recoveries of overpayments to LDH in situations where the MCE is not permitted to retain some or all of the recoveries of overpayments.</li> <li>c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.</li> </ul> <p><b>MCO:</b></p> <ul style="list-style-type: none"> <li>a. <i>Report annually to LDH, in a form and format specified by LDH, on the MCO's recoveries of overpayments in accordance with 42 CFR §438.608.</i></li> </ul> <p><b>PAHP:</b></p> <ul style="list-style-type: none"> <li>a. <i>The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.</i></li> </ul>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Overpayment tracking mechanisms</li> <li>• Provider materials, such as the provider manual and provider contract</li> <li>• Staff training materials</li> <li>• Most recent report of recoveries of overpayments to State</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2024_National_Program_Integrity_Plan_Plan.pdf, Pg. 14</li> <li>• 7_185 Finance Report</li> <li>• 2-8. 12-13, 18_ElevanceHealth_SIU 06-7, 13 Antifraud_Plan.pdf, Pgs. A24-A25</li> <li>• 7_Reporting of Fraud and Abuse Investigations.pdf, entire document</li> <li>• 6, 7_Overpayments.pdf, entire document</li> <li>• 6, 7, 13 LA PI145_FWA_Quarterly Report_Q424.xls entire document</li> </ul>	<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Met</li> <li><input type="checkbox"/> Not Met</li> <li><input type="checkbox"/> NA</li> </ul>



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<p>b. <i>The PAHP shall report to LDH Program Integrity at least monthly all unsolicited provider refunds, to include any payments submitted to the Contractor and/or its subcontractors by providers for overpayments identified through self-audit and/or self-disclosure.</i></p> <p>PIHP:</p> <p>a. <i>The Contractor shall report to LDH Program Integrity at least quarterly all audits performed and overpayments identified and recovered by the Contractor and all of its providers and subcontractors. Reporting must specify which overpayments are attributed to potential fraud.</i></p> <p>b. <i>The PIHP 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.</i></p> <p style="text-align: right;">42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3)</p> <p>MCO Contract: 2.20.2.2.15; 2.20.7.3 PAHP Contract: 2.12.2.4; 2.12.5.2.15; 2.12.6.3.1.4; 2.12.6.3.1.5; 6.3.6.3; 2.12.6.3.2; 2.12.6.3.3; 2.12.6.3.4 PIHP Contract: 13.5.5; 13.5.6</p>	<ul style="list-style-type: none"> <li>• 5-8, 18 Healthy Blue Provider manual.pdf, Pgs. 177-179</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" outlines rigorous procedures for recovering overpayments and specifies the necessity for annual reporting to the Louisiana Department of Health (LDH). It indicates that the Special Investigations Unit (SIU) is tasked with identifying, investigating, and recovering overpayments due to fraud, waste, and abuse. The plan details the use of data mining and predictive modeling to track overpayment trends and ensure financial accuracy in claims, reinforcing compliance with 42 CFR §438.608. By emphasizing collaboration with various departments and maintaining extensive records for at least ten years, the plan ensures transparency and</li> </ul>		



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<p>accountability in its recovery processes. This structured approach to documenting and reporting financial recoveries demonstrates compliance with LDH's requirements for annual reporting on overpayments, as specified in the regulation.</p> <ul style="list-style-type: none"> <li>○ The "Reporting of Fraud and Abuse Investigations.pdf" document outlines the procedures of the Special Investigations Unit (SIU) for reporting fraud and abuse investigations, and it directly supports compliance with reporting requirements, such as the annual reporting of overpayments to the Louisiana Department of Health (LDH) as specified in 42 CFR §438.608. The document establishes that the SIU must provide comprehensive reports to state authorities that include details like the number of fraud and abuse complaints warranting preliminary investigations, and for each case requiring a full investigation, the provider's information, the source and nature of the complaint, the dollar amount involved, and the actions of law enforcement. These systematic reporting requirements ensure that all overpayments identified as resulting from potential fraud are meticulously documented and communicated to the LDH in a manner that meets federal and state guidelines. By adhering to these protocols, the SIU aligns with the contractual obligations set forth by LDH for annual reporting of overpayment recoveries, ensuring transparency and accountability in fraud detection and restitution efforts.</li> <li>○ The document "D7, D8, E1.1_Overpayments.pdf" establishes detailed procedures for the prompt reporting and recovery of overpayments, ensuring compliance with both state and federal regulations, including 42 CFR §438.608. It mandates that overpayments must be reported and returned within 60 days of identification, with potential fraud cases specifically requiring notification to involved parties within 10 days. An annual report on recoveries must be submitted to the Department of Health Care Services using a specified template, reinforcing transparency and accountability. The document also highlights the necessity for Managed Care Plans to include detailed documentation and timely communication with state agencies upon identifying any overpayment, thereby demonstrating a structured approach to compliance and fraud prevention.</li> <li>○ The "LA PI145_FWA_Quarterly_Report_Q424.xlsx" document shows all cases and leads with activity during the quarter being reported. This includes cases opened in the report quarter, closed in the report quarter, or opened prior to the report quarter and remaining open. It documents all audit activities performed by the Company, reports all issues where overpayments were identified because of provider activity, and reports all recovery activity performed.</li> <li>○ The "Healthy Blue Provider Manual" comprehensively details procedures for the prompt reporting and recovery of overpayments, including those potentially related to fraud, thereby demonstrating compliance with state and federal requirements. It emphasizes the obligation to report and return overpayments within 60 days to avoid penalties under the False Claims Act, aligning with the Patient Protection and Affordable Care Act's mandates. The manual outlines a structured process for notifying providers of identified overpayments, specifying reasons for recoupment, and allowing a 60-day response period before proceeding with recovery actions. Healthy Blue also provides a system for reporting these recoveries to the Louisiana Department of Health (LDH), meeting the requirements set by 42 CFR §438.608. The adherence to specific timelines for action and the capacity for providers to request independent reviews of adverse determinations further illustrate</li> </ul>		



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<p>regulatory compliance. Overall, the document effectively ensures that Healthy Blue meets its contractual and legal obligations for managing and reporting overpayment recoveries, as specified by the terms of the contract with LDH.</p> <ul style="list-style-type: none"> <li>○ The 2024 National Program Integrity Plan defines how PI has developed procedures for the treatment of recoveries for identified overpayments. Elevance Health ensures state and federal regulations are reviewed to assure the timing of refund requests and notification requirements are valid.</li> </ul>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>8. The MCE requires and has a mechanism for a network provider to report to the MCE when it has received an overpayment, to return the overpayment to the MCE within 60 calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.608(d)(2)</p> <p>MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Overpayment and monitoring mechanisms</li> <li>• Provider materials, such as the provider manual and provider contract</li> <li>• Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2024_National_Program_Integrity_Plan_Plan pdf, Pgs.16-19</li> <li>• 2-8.12-13, 18_ElevanceHealth_SIU Antifraud_Plan.pdf, Pgs. A12, A20, 17</li> <li>• 6-8, 13 LA PI145_FWA_Quarterly Report Q424.xlsx, entire document</li> <li>• 05-08, 18_Healthy Blue Provider Manual, Pgs. 177-179</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" establishes a clear procedure for Network Providers to report and return overpayments, enhancing the transparency and efficiency of handling financial discrepancies. Providers are required to report overpayments to the Contractor within sixty calendar days of identification, ensuring a prompt resolution and return of funds. Along with returning the overpayment, providers must provide written notification detailing the reason for the overpayment to ensure comprehensive documentation and analysis. This structured approach facilitates consistent communication and accountability between providers and the Contractor, highlighting the importance of accurate financial management. The document's clear guidelines and timelines demonstrate compliance with contractual requirements, promoting integrity and accountability in financial operations.</li> <li>○ The "LA PI145_FWA_Quarterly_Report_Q424.xlsx" document shows all cases and leads with activity during the quarter being reported. This includes Provider self-audit and unsolicited refunds received during the quarter being reported. It documents all audit activities performed by the Company, reports all issues where overpayments were identified because of provider activity, and reports all recovery activity performed.</li> <li>○ The "Healthy Blue Provider Manual" clearly outlines procedures for network providers to handle overpayments, ensuring compliance with regulatory requirements. According to the document, upon identifying an overpayment, providers are instructed to notify Healthy Blue and return the overpayment within sixty (60) calendar days. The manual also specifies that providers should include a completed Refund Notification Form when returning an overpayment, which details the reason for the overpayment. This structured process ensures that providers comply with the requirement to report overpayments promptly and provide justification, aligning with the payment recoupment process as outlined by the regulations. By detailing these protocols, the manual ensures that both Healthy Blue and its network providers meet their contractual and regulatory obligations regarding overpayments.</li> <li>○ The 2024 National Program Integrity Plan outlines how the Provider Audit Unit ensures services were billed appropriately, and reimbursement was accurate. The team uses both desk and on-site reviews to complete these audits and may be performed by either an employee or a contracted vendor auditor. Providers are offered standard reconsideration/appeal rights as outlined in their provider agreements.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<b>Notification of Member and Provider Changes</b>		
<p>9. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>● Policies and procedures</li> <li>● Staff training materials</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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<p>LDH and the MCE) implements and maintains arrangements or procedures for prompt notification to LDH when it receives information about changes in a member’s circumstances that may affect the member’s eligibility including all of the following:</p> <ul style="list-style-type: none"> <li>a. Changes in the member’s residence;</li> <li>b. The death of a member.</li> </ul> <p style="text-align: right;">42 CFR §438.608(a)(3)</p> <p>MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 09_Disenrollment and Enrollment – LA Policy and Procedure pg 8</li> </ul>	<input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The policy describes how/what the health plan does when notified of a members death or address change within file exchanges. Also, when UM/CM teams identify member deaths or out of state addresses, they are reported to health plan enrollment via email. The information is updated on the 834 data feed to LDH.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>10. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for notification to LDH when it receives information about a change in a network provider’s circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCE.</p> <p>PAHP:</p> <ul style="list-style-type: none"> <li>a. <i>The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider</i></li> </ul>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Staff training materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 10.a BLAPEC-0603-17_Provider Termination Without Cause Letter Template.pdf</li> <li>• 10.a Terminations Report JAN.FEB. MARCH</li> <li>• 10, 17 Provider Network and Management - LA 47607.pdf</li> <li>• 10 LA Provider Enrollment DPL</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA



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<p><i>becoming unable to care for enrollees due to provider illness, a provider dies, the provider moves from the service area and fails to notify the PAHP, 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. The notification shall include:</i></p> <ol style="list-style-type: none"> <li>i. <i>Information about how the provider network change will affect the delivery of covered services; and</i></li> <li>ii. <i>The PAHP’s plan for maintaining the quality of enrollee care if the provider network change is likely to affect the delivery of covered services.</i></li> </ol> <p><b>PIHP:</b></p> <ol style="list-style-type: none"> <li>a. <i>The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, 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:</i> <ol style="list-style-type: none"> <li>i. <i>Information about how the provider network change will affect the delivery of covered services, and</i></li> <li>ii. <i>The PIHP’s plan for maintaining the quality of member care if the provider network change is likely to affect the delivery of covered services.</i></li> </ol> </li> </ol> <p style="text-align: right;">42 CFR §438.608(a)(4)</p> <p>MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5</p>	<ul style="list-style-type: none"> <li>• 10 PDM_LA_Service Areas</li> </ul>	



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<p><b>MCE Description of Process:</b> Report termination notification outlier data associated with physical and behavioral health providers, with the expectation that barriers or issues negatively impacting compliance with R.S. 46:460.72 (Act 489) are documented and addressed. Provider initiated terminations should also be reported on this tab. Terminations issued because of failure to comply with the re-credentialing process should not be included.</p> <p>Provider Enrollment – Providers can request enrollment through the Availity Digital Provider Enrollment system. After Healthy Blue LA receives the application, it is forwarded to the credentialing department if credentialing is needed, and then the provider is entered into the claims payment system. Quality checks are performed before the application process is finalized to ensure the provider's information is accurately recorded. Providers can monitor the status and completion of their application via the Availity Dashboard. Any specific nuances for Health Blue are outlined within the Desk Level Procedures that have been supplied.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Verification of Services Provided		
<p>11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.</p> <p>MCO:</p> <p>a. <i>On a monthly basis, the MCO shall provide individual explanation of benefits (EOB) notices to a sample group of Enrollees, not more than forty-five (45) calendar days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice shall specify:</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Methodology for verifying services</li> <li>Most recent results from the Medicaid verification of services activity</li> <li>Staff training materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>11 Explanation of Benefits (EOB) and Related Functions-LA Policy and Procedure</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 Member Verification of Services-LA</li> <li>Report 147 submitted per Member Verification of Services-LA Page 2 Procedure #3.c</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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<ul style="list-style-type: none"> <li>i. <i>Description of the service furnished;</i></li> <li>ii. <i>The name of the provider furnishing the service;</i></li> <li>iii. <i>The date on which the service was furnished;</i></li> <li>iv. <i>The amount of the payment made for the service; and</i></li> <li>v. <i>The method for notifying the Contractor of services not rendered.</i></li> <li>b. <i>The Contractor shall stratify the paid Claims sample to ensure that all provider types (or specialties) and all Claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the Contractor or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the Contractor may over sample the group. The paid Claims sample shall be a minimum of two percent (2%) of paid Claims per month to be reported to LDH on a quarterly basis.</i></li> <li>c. <i>The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).</i></li> <li>d. <i>The Contractor shall track any responses received from Enrollees and resolve the responses according to its established policies and procedures. The resolution may be effected through member education, provider education, payment recovery, or referral to LDH. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i></li> <li>e. <i>Within three (3) business days of receipt of a response from an enrollee, results indicating that paid services may not have been received shall be referred to the</i></li> </ul>		



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<p><i>MCO’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include, at a minimum, the total number of notices sent to enrollees, total number of services sent for validation, total number of responses completed, total services requested for validation, number of services validated, analysis of interventions related to resolution, and number of responses referred to LDH for further review.</i></p> <p><b>PAHP:</b></p> <p>a. <i>On a monthly basis, the PAHP shall provide individual explanation of benefits (EOB) notices to a sample group of members, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:</i></p> <ul style="list-style-type: none"> <li>i. <i>Description of the service furnished;</i></li> <li>ii. <i>The name of the provider furnishing the service;</i></li> <li>iii. <i>The date on which the service was furnished; and</i></li> <li>iv. <i>The amount of the payment made for the service.</i></li> </ul> <p>b. <i>Stratify paid claims sample to ensure that all provider types (or specialties) and all claim types are proportionally represented in the sample pool from the entire range of services available under the Contract. To the extent that the DBPM or LDH considers a particular specialty (or provider) to warrant closer scrutiny, the DBPM may over sample the group. The paid claims sample should be for a minimum of two (2%) percent of claims paid per month to be reported on a quarterly basis.</i></p>		



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<p>c. <i>The PAHP shall also perform surveys at any point after a claim has been paid. This sampling may be performed by mail, telephonically or in person (e.g., case management on-site visits); and</i></p> <p>d. <i>Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.</i></p> <p>e. <i>Within three (3) business days, results indicating that paid services may not have been received shall be referred to the PAHP’s fraud and abuse department for review and to the LDH Program Integrity contact.</i></p> <p>f. <i>Reporting shall include the total number of survey notices sent out to enrollees, total number of surveys completed, total services requested for validation, number of services validated, analysis of interventions related to complaint resolution, and number of surveys referred to LDH for further review.</i></p> <p><b>PIHP:</b></p> <p>a. <i>On a monthly basis, the Contractor shall provide individual EOB notices to a sample group of the members who received services, not more than forty-five (45) days from the date of payment, in a manner that complies with 42 CFR §455.20 and §433.116(e). The required notice must specify:</i></p> <ul style="list-style-type: none"> <li>i. <i>The service furnished;</i></li> <li>ii. <i>The name of the provider furnishing the service;</i></li> <li>iii. <i>The date on which the service was furnished; and</i></li> <li>iv. <i>The amount of the payment made for the service.</i></li> </ul> <p>b. <i>The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The</i></p>		



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<p><i>sample should be a minimum random sample of at least sixty-five (65) members per month who received a paid service to be reported on a quarterly basis. The Contractor shall submit the methodology to LDH for prior approval.</i></p> <p>c. <i>Surveys shall be performed within forty-five (45) days after a claim has been paid. This sampling may be performed by mail, telephonically, or in person (e.g., case management on-site visits). Concurrent review will be allowed when tied back to a successfully adjudicated claim.</i></p> <p>d. <i>The Contractor shall over sample particular provider groups upon request by LDH.</i></p> <p>e. <i>The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.</i></p> <p>f. <i>Within five (5) business days, results indicating that paid services may not have been received shall be referred to the Contractor’s fraud and abuse department for review and to LDH’s designated Program Integrity contact.</i></p> <p>g. <i>The Contractor shall provide a quarterly report to LDH regarding the EOB results from sample group notices in a format to be approved by LDH. This report shall include attestations certifying EOBs were developed and sent to beneficiaries, and that the beneficiaries were provided sixty (60) days for comment and suggestion. The attestation form will be provided by LDH.</i></p>		



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MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6. PIHP Contract: 15.4	42 CFR §438.608(a)(5)	
<p><b>MCE Description of Process:</b> Explanation of benefits policy outlines our process and procedures used to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Whistleblower Protection		
<p>12. In the case of MCEs that make or receive annual payments under the contract of at least \$5,000,000, the MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures, written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers.</p> <p>MCO:</p> <p>a. Include in any employee handbook for the MCO, a specific discussion of the laws, the rights of employees to be protected as whistleblowers and the MCO’s policies and procedures for detecting and preventing fraud, waste and abuse.</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Program integrity/compliance plan</li> <li>Staff, Provider, and Subcontractor training/informational materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2024_National_Program_Integrity_Plan_Plan.pdf, Pg. 25</li> <li>2-8, 12-13, ElevanceHealth SIU Antifraud Plan.pdf, Pgs. 18-20</li> <li>2, 12-13_2024 Do The Right Thing Script.pdf</li> <li>2, 12-13 2024 Do The Right Thing Certification Module.pdf</li> <li>2, 12-13 Louisiana Medicaid SIU_Training Roster_CY2024, entire document</li> <li>2, 5, 12_2024 Elevance Code of Conduct pg.29</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
42 CFR §438.608(a)(6)		



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Requirement	Supporting Documentation	Score
MCO Contract: 6.18.1; 6.18.3 PAHP Contract: 2.12.5.2.6.4; 2.12.5.2.6.7 PIHP Contract: 13.1.1.2.; 13.1.2.8		
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" outlines comprehensive written policies that provide all employees, including management and subcontractors, with detailed information about the False Claims Act under 31 U.S.C. §§3729 through 3733. This includes descriptions of administrative remedies for false claims under 31 U.S.C. Chapter 38, and outlines state laws regarding penalties for false claims and whistleblower protections. The document emphasizes the role of these laws in preventing and detecting fraud, waste, and abuse in federal healthcare programs. It demonstrates compliance with the requirement by ensuring these policies are integrated into employee training and resources, such as the employee handbook. This includes specific discussions of the laws, rights under whistleblower protections, and the company’s procedures for addressing fraud, waste, and abuse, illustrating a strong commitment to legal and ethical standards across the organization.</li> <li>○ The "L1_FA_04_2024 Do The Right Thing Script US ENG.pdf" document comprehensively addresses the establishment of written policies for all employees, including management and subcontractors, with detailed information about the False Claims Act as required under 31 U.S.C. §§3729 through 3733. It explains administrative remedies for false claims and statements and covers state laws regarding civil or criminal penalties, along with whistleblower protections under these laws. These inclusions highlight the document's focus on educating employees about their legal responsibilities and rights, particularly emphasizing their role in preventing and detecting fraud, waste, and abuse in federal health care programs. Additionally, the document ensures that the employee handbook includes a specific discussion about these laws, employee rights as whistleblowers, and the company's policies and procedures to address fraud, waste, and abuse effectively. By detailing these elements, the document demonstrates compliance with the requirements to provide comprehensive information and support the enforcement of ethical practices within the organization.</li> <li>○ The "2024 Do The Right Thing Certifications Module.pdf" outlines the certifications that employees are required to complete as part of the training detailed in the “2024 Do The Right Thing Script.pdf.” These certifications ensure that employees are well-versed in ethics, compliance, privacy, and information security within their roles, adhering to Elevance Health's standards for protecting confidential information and maintaining overall organizational integrity.</li> <li>○ The “Louisiana Medicaid SIU_Training Roster_CY2024” displays all SIU Associates that supports (or) supported Medicaid for the state of Louisiana during the audit timeframe and their Do the Right Thing Training and all other annual training completion.</li> <li>○ The 2024 National Program Integrity Plan outlines how PI maintains written policies, as well as training, for all employees and subcontractor employees that provide detailed information about the False Claims Act and state laws pertaining to civil or criminal penalties for false claims. These policies also cover whistleblower protections and ensure that no one employed by or contracted with our Company retaliates against</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
any individual who reports Compliance violations or suspected FWA. For additional details, Fraud, Waste and Abuse Detection and Prevention in Health Plan Operations Policy is available upon request.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Fraud, Waste, and Abuse		
<p>13. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures:</p> <p>a. That are designed to detect and prevent fraud, waste, and abuse.</p> <p>b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH’s program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU).</p> <p><b>PAHP:</b></p> <p>a. <i>The PAHP shall be responsible for promptly reporting suspected fraud, abuse, waste and neglect information to the state office and Attorney General Medicaid Fraud Control Unit (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).</i></p> <p><b>PIHP:</b></p> <p>a. <i>The PIHP shall establish policies and procedures for referral of suspected fraud, waste and abuse to the LDH Program Integrity Office and Law Enforcement. A</i></p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Fraud, waste, and abuse plan</li> <li>• SIU workflow</li> <li>• Reporting mechanisms</li> <li>• Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2024_National_Program_Integrity_Plan_Plan.pdf, Pgs. 19-30</li> <li>• 2-8, 12-13, 18_ElevanceHealth_SIU Antifraud_Plan.pdf, entire document</li> <li>• 3, 4, 13 Investigations of Suspected Fraud and Abuse.pdf, entire document</li> <li>• 13_Investigative_Actions_SIU_Flowchart.pdf, entire document</li> <li>• 6, 7, 13_Reporting of Fraud and Abuse Investigations.pdf, entire document</li> <li>• 13_Healthy Blue Tips Report_12162024.xlsx, entire document</li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p style="text-align: center;"><i>standardized referral process should be developed to expedite information for appropriate disposition.</i></p> <p style="text-align: center;">42 CFR §438.608(a) 42 CFR §438.608(a)(7)</p> <p>MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4</p>	<ul style="list-style-type: none"> <li>06-08, 13_LA PI145_FWA Quarterly Report Q424.xlsx, entire document</li> <li>02, 12-13 2024 Do The Right Thing Script.pdf</li> <li>02, 12-13 2024 Do The Right Thing Certification Module.pdf</li> <li>02, 12-13 Louisiana Medicaid SIU_Training Roster_CY2024, entire document</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" comprehensively addresses the requirement for contractors receiving annual payments of five million dollars or more to maintain robust written policies and procedures for detecting and preventing Fraud, Waste, and Abuse (FWA), in compliance with 42 U.S.C. §1396a(a)(68). The document details the responsibilities of the Special Investigations Unit (SIU), which includes utilizing data analysis, predictive modeling, and provider audits to identify and investigate potential fraud. It emphasizes the importance of training programs for associates, ensuring they are equipped to recognize and report FWA effectively. Additionally, the plan outlines collaboration with law enforcement and the use of a web-based system for detailed documentation and case tracking, demonstrating a structured and proactive approach to FWA. This comprehensive strategy highlights Elevance Health's commitment to regulatory compliance and integrity in handling substantial financial transactions and risks associated with federal healthcare programs.</li> <li>○ The "Red Flags Checklist and Guide.pdf" document is designed to guide associates in identifying potential signs of fraud, waste, and abuse (FWA) within the organization, thereby meeting the compliance requirements outlined in 42 U.S.C. §1396a(a)(68). This checklist provides detailed provisions and serves as a critical tool within the company's written policies for detecting suspicious activities and preventing unnecessary costs. By offering a structured set of indicators, such as unusual billing patterns and discrepancies in service documentation, the document equips staff with the necessary insights to recognize and escalate potential FWA cases effectively. Thus, it plays a vital role in the Company's broader antifraud strategy, ensuring proactive detection and prevention measures are deeply integrated into daily operations, thereby demonstrating compliance with federal regulations for maintaining integrity in handling substantial financial transactions within Medicaid programs.</li> <li>○ The "Investigations of Suspected Fraud and Abuse.pdf" document details a systematic approach involving the use of advanced tools such as coding software and proprietary analytics to detect anomalies in provider billing behaviors. It further explains the investigative process, which includes conducting preliminary and full investigations to substantiate allegations and determine appropriate actions, such as prepayment reviews or referring cases to law enforcement. By articulating these detailed procedures, the document underscores the Company's</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

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Requirement	Supporting Documentation	Score
<p>commitment to an effective fraud prevention framework, ensuring robust oversight and adherence to federal mandates for maintaining the integrity of Medicaid programs.</p> <ul style="list-style-type: none"> <li>○ The "Investigative_Actions_SIU_Flowchart.pdf" outlines the Special Investigations Unit's (SIU) workflow for handling Fraud, Waste, and Abuse (FWA) investigations. It maps the process from the initial claim data request through decisions about continuing the investigation, notifying agencies, or taking remedial actions like education or overpayment recovery. The flowchart provides a systematic guide for investigations and serves as a visual guide for ensuring methodical and thorough FWA investigations.</li> <li>○ The "Reporting of Fraud and Abuse Investigations.pdf" document outlines the comprehensive procedures and policies of the Special Investigations Unit (SIU) for addressing fraud and abuse, ensuring compliance with obligations specified for contractors with annual payments of five million dollars or more under 42 U.S.C. §1396a(a)(68). This document thoroughly details the SIU's approach to identifying, investigating, and reporting suspected cases of fraud, waste, and abuse (FWA). It includes structured processes for receiving and categorizing allegations through various channels such as fraud hotline complaints and claims data mining and specifies the criteria for determining when these allegations merit preliminary or full investigations. The document also describes the mandatory reporting components, such as the need to include the provider's details, nature of the complaint, the dollar amounts involved, and the legal outcomes of each investigation when reporting to state officials. By articulating these procedures, the document demonstrates the Company's compliance with federal regulations to effectively detect and prevent FWA, reflecting a robust antifraud strategy integral to safeguarding the Medicaid program's integrity.</li> <li>○ The "Healthy Blue Tips Report_12162024.xlsx" shows all leads, tips, complaints opened during the month being reported (December 2024.) This includes the source or mechanism which identified the potential fraud, waste, and abuse in addition to the statement, claim, indication, circumstance related to the offense during the month being reported.</li> <li>○ The "LA PI145_FWA_Quarterly_Report_Q424.xlsx" document shows all cases and leads with activity during the quarter being reported (Q4 2024, October-December.) This includes the source or mechanism which identified the potential fraud, waste, and abuse during the quarter being reported. It documents all audit activities performed by the Company, reports all issues where overpayments were identified because of provider activity, and reports all recovery activity performed.</li> <li>○ The "2024 Do The Right Thing Script.pdf" document outlines comprehensive policies and procedures for detecting and preventing Fraud, Waste, and Abuse (FWA), in compliance with the requirements stipulated by 42 U.S.C. §1396a(a)(68). It includes sections defining FWA and emphasizes the importance of vigilance against these issues, highlighting responsibilities for associates to report any suspected incidents. The document details several red flags related to provider and member fraud, guiding employees on how to identify potential issues. It also establishes the role of the Special Investigations Unit (SIU) in managing FWA concerns and provides multiple channels for reporting, ensuring a transparent and supportive environment for compliance adherence. By integrating these elements, the document thoroughly demonstrates adherence to federal mandates by outlining Elevance Health's commitment to maintaining integrity and accountability in managing risks associated with FWA.</li> </ul>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>○ The "2024 Do The Right Thing Certifications Module.pdf" outlines the certifications that employees are required to complete as part of the training detailed in the "2024 Do The Right Thing Script.pdf." These certifications ensure that employees are well-versed in ethics, compliance, privacy, and information security within their roles, adhering to Elevance Health's standards for protecting confidential information and maintaining overall organizational integrity.</li> <li>○ The "Louisiana Medicaid SIU_Training Roster_CY2024" displays all SIU Associates that supports (or) supported Medicaid for the state of Louisiana during the audit timeframe and their Do the Right Thing Training and all other annual training completion.</li> <li>○ The 2024 National Program Integrity Plan outlines how PI's reporting requirements are met based on local, state, and federal laws and/or statutes and/or contact. PI has procedures and systems in place for prompt reporting of all overpayments identified due to potential administrative and non-administrative FWA.</li> </ul>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Suspension of Payments		
<p>14. The MCE, and all applicable subcontractors, implements and maintains arrangements or procedures for the suspension of payments to a network provider for which LDH determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>● Policies and procedures</li> <li>● Payment suspension workflow</li> <li>● Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>● 14, 15_Provider Payment suspension (hold) - LA (Entire Document)</li> <li>● 14,15_Medicaid Payment Withhold Process - LA Reference Guide (Entire Document)</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
MCE Description of Process:		
<ul style="list-style-type: none"> <li>○ The "14, 15 Provider Payment Suspension (Hold) -LA" serves as the policy and procedure and workflow for the payment suspension process. This document outlines the entire payment suspension process to ensure compliance with LDH requirements for updating in our systems to suspend payment when notified of credible allegations of fraud or other allowable reasons.</li> </ul>		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>○ The MCE uses “14,15 Medicaid Payment Withhold Process – LA Reference Guide” as staff training material. This document is a comprehensive outline of the implementing payment withholds, releasing payment withholds, and details how to access payment withhold reporting. Also, this document demonstrates compliance with requirements to provide hold information to LDH OIG upon request by showing the plan process to access reporting.</li> </ul>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>15. The MCE, and all applicable subcontractors, issues a notice of payment suspension that comports with 42 CFR §455.23(b) and retains the suspension in accordance with 42 CFR §455.23(c).</p> <p style="text-align: right; margin-right: 100px;">42 CFR §438.608(a)(8) 42 CFR §455.23</p> <p>MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Payment suspension workflow, including applicable timeframes</li> <li>Notice of payment suspension letter template</li> <li>Staff training materials</li> <li>HSAG will also use findings from the provider payment suspensions tracking system demonstration</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>14, 15_Provider Payment suspension (hold) - LA (Payment Suspension section, #6)</li> <li>14,15 Medicaid Payment Withhold Process - LA Reference Guide (Entire Document)</li> <li>15_LA Payment Suspension Template (Entire Document)</li> </ul> <hr/> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Medicaid Payment Withhold Process - LA Reference Guide</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Provider Payment Withhold Form</li> <li>Provider Payment Suspension (Hold) -LA Policy and Procedure</li> <li>Provider Levy Garnishment Example</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>o The “14, 15 Provider Payment Suspension (Hold) -LA” serves as the policy and procedure and workflow for the payment suspension process. This document outlines the entire payment suspension process to ensure compliance with LDH requirements for updating in our systems to suspend payment when notified of credible allegations of fraud or other allowable reasons. Also, this document demonstrates compliance with applicable timeframe for notifying providers.</li> <li>o The MCE uses “14,15 Medicaid Payment Withhold Process – LA Reference Guide” as staff training material. This document is a comprehensive outline of the implementing payment withholds, releasing payment withholds, and details how to access payment withhold reporting. Also, this document demonstrates compliance with requirements to provide hold information to LDH OIG upon request by showing the plan process to access reporting.</li> <li>o The “15_LA Payment Suspension Template” is the notice of payment suspension letter templated used to notify providers they are being placed on payment suspension as directed by LDH. This document demonstrates compliance with 42 CFR 455.23(b)(c).</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Provider Screening and Enrollment Requirements		
<p>16. The MCE ensures that all network providers are enrolled with LDH as Medicaid providers consistent with the provider disclosure, screening, and enrollment requirements of part 455, subparts B and E.</p> <p style="text-align: right; margin-right: 50px;">42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E</p> <p>MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Medicaid enrollment verification workflow</li> <li>Two examples of documented Medicaid enrollment verifications</li> <li>Staff training materials</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li></li> </ul>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>LA DLP 2025.pdf</li> <li>DPE Ticket Compliance Example</li> <li>Verification Process for LA Medicaid</li> </ul>	
<b>MCE Description of Process:</b>		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days.</p> <p style="margin-left: 20px;">a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members.</p> <p style="text-align: right; margin-right: 20px;">42 CFR §438.602(b)(2)</p> <p>MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5</p>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>Medicaid enrollment timeliness tracking mechanisms</li> <li>Staff training materials</li> </ul> <hr/> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>10,17 - Provider Network and Management - LA 47607.pdf</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Verification Process for LA Medicaid Sections 2 and 3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> The provided document "10,17 - Provider Network and Management - LA 47607.pdf" details the policies and procedures guiding the MCE development and management of a provider network. It outlines procedures for notifying the Louisiana Department of Health (LDH) about any material changes in the network that could affect service delivery, and strategies for maintaining service continuity. The policies ensure that all providers comply with licensing and payment requirements.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		



## Louisiana Department of Health 2025 Compliance Review for Healthy Blue

Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Disclosures and Prohibited Affiliations</b>		
<p>18. The MCE, and any subcontractors:</p> <ul style="list-style-type: none"> <li>a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610.</li> <li>b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104.</li> <li>c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract.</li> </ul> <p><b>MCO:</b></p> <ul style="list-style-type: none"> <li>a. <i>Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars (\$25,000), even if there is no suspicion of fraudulent activity.</i></li> </ul> <p style="text-align: right;">42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610</p> <p>MCO Contract: 2.20.3.6; 2.20.7.2 PAHP Contract: 6.7.3.1; 2.15.12 PIHP Contract: 13.2.1; 13.2.2.1; 13.1.2.13</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures that apply to provider/contracted entities and the MCE</li> <li>• Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership)</li> <li>• Disclosure of ownership and control notice template (required for completion by contracted entities)</li> <li>• Confirmation MCE disclosures were provided to LDH upon contract execution</li> <li>• Staff training materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 18_0170_Disclosure of Ownership Template</li> <li>• 18_ElevanceHealth_SIU_Antifraud_Plan.pdf, Pgs. A12, A20, 17</li> <li>• 18_Healthy Blue Provider Manual, Pgs. 138-144, 177-179</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>○ The "ElevanceHealth_SIU_Antifraud_Plan.pdf" demonstrates compliance with the requirements of 42 CFR §438.608 and §438.610 through comprehensive measures targeting debarment and suspension. The plan mandates screenings of all employees, contractors, and Network Providers to ensure none are excluded from participating in Medicare, Medicaid, the Children’s Health Insurance Program, and other federal health care programs. This screening process adheres to the requirements set forth in 42 CFR §455.436, ensuring thorough vetting to maintain compliance. Furthermore, the document obligates the organization to notify the Louisiana Department of Health (LDH) in writing whenever voluntary provider disclosures result in overpayments exceeding \$25,000, regardless of fraud suspicion. These outlined procedures illustrate</li> </ul>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p>Elevance Health's commitment to upholding regulatory standards and maintaining transparency with state and federal health care oversight entities.</p> <ul style="list-style-type: none"> <li>○ The "Healthy Blue Provider Manual" thoroughly demonstrates compliance with the requirements set forth by 42 CFR §438.608 and §438.610 regarding debarment and suspension. The document mandates that both Healthy Blue and its subcontractors conduct rigorous screening of all employees, contractors, and network providers to ensure they have not been excluded from participating in Medicare, Medicaid, the Children’s Health Insurance Program, or any federal healthcare programs. This includes adherence to the screening procedures outlined in 42 CFR §455.436. Additionally, the manual specifies a clear protocol for notifying the Louisiana Department of Health (LDH) in writing upon receiving voluntary provider disclosures that lead to overpayments exceeding \$25,000, ensuring transparency even when there is no suspicion of fraud. By outlining these processes, the document ensures systematic compliance with federal regulations and establishes effective oversight and reporting mechanisms to prevent prohibited affiliations and manage significant overpayment situations.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		

Results for Standard XIV—Program Integrity							
<b>Total</b>	Met	=	18	X	1	=	18
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	18	<b>Total Score</b>		=	18

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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## Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	Evidence as Submitted by the MCE		Score
1.  Contract: <Insert Citation(s)> <div style="float: right; text-align: right;">             &lt;Insert federal CFR citation&gt;           </div>	<b>HSAG Required Evidence:</b>  <b>MCE Document Submission:</b> <ul style="list-style-type: none"> <li></li> </ul>		<input type="checkbox"/> Met  <input type="checkbox"/> Not Met
<b>HSAG Findings:</b>			
<b>Required Actions:</b>			
<b>Interventions Planned</b>	<b>Intervention Evaluation Method</b>	<b>Individual(s) Responsible</b>	<b>Proposed Completion Date</b>
<b>CAP Approval Status:</b>			
<b>Submission:</b>			