



# 2025 External Quality Review Compliance Review

*for*

## Louisiana Healthcare Connections

*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 Louisiana Healthcare Connections (LHCC). 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	24	0	0	100%
III	Member Information	19	18	12	6	1	67%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	15	9	6	0	60%
VI	Coordination and Continuity of Care	12	12	11	1	0	92%
VII	Coverage and Authorization of Services	23	21	21	0	2	100%
VIII	Provider Selection	19	19	16	3	0	84%
IX	Subcontractual Relationships and Delegation	6	6	4	2	0	67%
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	37	0	1	100%
XIV	Program Integrity	18	18	17	1	0	94%
<b>Total Compliance Score</b>		<b>227</b>	<b>218</b>	<b>199</b>	<b>19</b>	<b>9</b>	<b>91%</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

LHCC 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 LHCC 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 LHCC into full compliance with the deficient requirements. LHCC must use this template to submit its CAP to bring any elements scored as *Not Met* into compliance with the applicable standard(s). LHCC'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 LHCC 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 LHCC 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 LHCC in its submitted CAP.

## Appendix A. Conclusions and Recommendations

Strengths	
	The MCE received 100 percent compliance with Standard I—Enrollment and Disenrollment Requirements and Limitations. 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.
	The MCE received 100 percent compliance with Standard II—Member Rights and Confidentiality, indicating that members were receiving timely and adequate access to information that can assist them in access care and services.
	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 compliance with Standard XIII—Grievance and Appeal Systems, demonstrating that the MCE had processes in place for handling member complaints, grievances, and appeals.
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.

## Appendix B. 2025 Compliance Review Tool

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



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## 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> <p>a. <i>When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department</i></p> <p>b. <i>Upon termination or expiration of the Contract</i></p> <p>c. <i>Death of the member</i></p> <p>d. <i>Confinement of the member in a facility or institution when confinement is not a covered service under the Contract</i></p> <p>PAHP:</p> <p>a. <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>PIHP:</p> <p>a. <i>The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.</i></p> <p style="text-align: right;">42 CFR §438.56(b)(1)</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• <u>LA.ELIG.02</u> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Disenrollment Process Flow Chart</li> <li>• Maximus Guide Disenrollment Tasks</li> <li>• Maximus Guide AWS</li> <li>• Disenrollment Systems LHCC and Maximus Communications and Tracking</li> <li>• Member Materials Member Handbook Screenshots</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 style="text-align: right;">42 CFR §457.1212</p> <p>MCO Contract: 2.3.12.3.2            PAHP Contract: 2.3.7.3.5; 2.3.7.3.1            PIHP Contract: 10.1.6</p>	<ul style="list-style-type: none"> <li>LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label DOD Disenroll Example 1</li> <li>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>As outlined in LA.Elig.02 page 1 section B paragraph 2:</p> <p style="padding-left: 40px;">“LHCC 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 Member ID Card to another person to obtain services. In such case, LHCC shall report the event to LDH. 2.3.13.3.1”</p> <p>Per LHCC Disenrollment Policy <u>LA.Elig.02</u> pages 1 &amp; 2 Disenrollments can be initiated by the Member (Member Requested), MCO (for example Date of Death and Out of State Address reported data updates) or initiated through Maximus and LDH. In the event a member requests disenrollment, LHCC transfers that member to the Medicaid State office.</p> <p>As outlined in LA.Elig.02 page 1 section A</p> <p style="padding-left: 20px;"><b>A.</b> Member Initiated Disenrollment (2.3.13.2) – The member (or his/ her representative) must submit an oral or written formal request to the State Enrollment Broker for disenrollment. Requests for disenrollment are not submitted by members directly to the MCOs.</p> <p>For Member initiated disenrollments a collaborative process has been developed between MCO/LDH to process requests submitted through Medicaid State Office / Maximus (The Enrollment Broker). Maximus tracks and manages Member Initiated Disenrollment requests via their system (MCO access is granted to the MCOs via a VPN to support feedback between the MCO and Enrollment Broker).</p> <ul style="list-style-type: none"> <li>See <u>Disenrollment Process Flow Chart</u> for a high level view of LHCC (MCO) initiated disenrollments vs the Maximus / State Enrollment Broker Processed Disenrollment requests.</li> <li>See the excel file with examples of Members Requesting disenrollment through Maximus sent to MCO for feedback - <u>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</u> (Once MCO provides Feedback to Maximus that is the end of our Line of Sight until a determination is made by LDH and all Member Requested Disenrollment data is within the Maximus VPN system not exportable / transferrable to the MCO systems).</li> </ul>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>▪ File contains 5 Member Examples (each Tab contains 1 Example) – of Maximus Tracked Types of Disenrollment Feedback Tasks that are sent to the MCO for Review.</li> <li>▪ File Contains Tab with high level process flow</li> <li>○ Technical Guides/Training materials provided by Maximus on the Maximus Disenrollment System are labelled as follows               <ul style="list-style-type: none"> <li>▪ Maximus Guide Disenrollment Tasks</li> <li>▪ Maximus Guide AWS</li> <li>▪ Disenrollment Systems LHCC and Maximus Communications and Tracking</li> </ul> </li> </ul> <p>LHCC / The MCO Initiated Disenrollments related to Date of Death and Out of State Addresses. These are sent over as PHI updates to LDH via LaMeds Reporting. After the data is sent to the State, LDH makes the determination to disenroll the member. This Disenrollment is then sent back to the MCO to formally disenroll the member via the 834 Eligibility Data files (Until the MCO receives an 834 disenrollment We cannot disenroll the member).</p> <ul style="list-style-type: none"> <li>○ See document workflow separation between LHCC vs Maximus Initiated Disenrollments -- <a href="#">Disenrollment Process Flow Chart</a></li> <li>○ 4 Example Members of LHCC initiated Date of Death and Out of State Disenrollments are on File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples see Tabs labelled DOD and OOS for Examples</li> </ul> <p>What you will see is that the Disenrollment process is a collaborative one between the MCO, LDH (state) and Maximus (enrollment broker). In cases where a member requests disenrollment (unrelated to a report of Date of Death or Out of State Address). These Disenrollments are managed by the state appointed broker Maximus. LHCC acts as a feedback loop (making an initial review within the Maximus system). Final reviews and Disenrollment decisions are ultimately processed by Maximus based on LDH determination. In cases where data / PHI updates can initiate a disenrollment (DOD and OOS) – this data is fed from the MCO -&gt; to LDH via LaMeds Reporting. The State makes the final determination/ updates the State Eligibility data → which then is sent back to the MCO via 834 Eligibility file records to finalize disenrollments.</p> <p><u>Summary of evidence:</u></p> <ul style="list-style-type: none"> <li>○ Disenrollment Policy – <a href="#">LA.ELIG.02</a> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>○ State Specific Workflow Documents:               <ul style="list-style-type: none"> <li>▪ Disenrollment Process Flow Chart</li> </ul> </li> <li>○ State Specific Technical Manuals from Maximus:</li> </ul>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>▪ Maximus Guide Disenrollment Tasks</li> <li>▪ Maximus Guide AWS</li> <li>▪ Disenrollment Systems LHCC and Maximus Communications and Tracking</li> <li>○ Member Materials - Member Materials Member Handbook Screenshots</li> <li>○ Case Example: LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label DOD Disenroll Example 1</li> <li>○ Maximus Case Example: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</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>2. The MCE does not request disenrollment because of:  MCO &amp; PAHP:</p> <ul 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> <li>d. The member’s diminished mental capacity</li> <li>e. The member’s pre-existing medical condition</li> <li>f. The member’s refusal of medical care or diagnostic testing</li> <li>g. The member’s attempt to exercise his/her rights under the Contractor’s Grievance system</li> <li>h. The member’s attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned</li> <li>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</li> </ul>	<p><b>HSAG Required Evidence:</b></p> <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 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>• LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Disenrollment Process Flow Chart</li> <li>• LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label Report LaMeds DOD and OOS 2024</li> <li>• Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>ability to furnish services to either this particular member or other members).</p> <p>PIHP:</p> <ul style="list-style-type: none"> <li>a. The member's adverse change in health status</li> <li>b. The member’s utilization of medical services</li> <li>c. The member’s diminished mental capacity</li> <li>d. The member’s uncooperative or disruptive behavior resulting from his or her special needs</li> </ul> <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><b>MCE Description of Process:</b></p> <p>As outlined in LA.Elig.02 page 1 section B paragraph 1:</p> <p style="padding-left: 40px;">“LHCC shall not request disenrollment because of a member’s health diagnosis, adverse change in health status, utilization of medical services, diminished medical capacity, pre-existing medical condition, refusal of medical care or diagnostic testing, uncooperative or disruptive behavior resulting from his or her special needs, unless it seriously impairs LHCC’s ability to furnish services to either this particular member or other LHCC members, the member attempts to exercise his/her rights under LHCC’s grievance system, or attempts to exercise his/her right to change, for cause, the primary care provider that he/she has chosen or been assigned. (42 CFR §438.56(b)(2)). 2.3.13.3.4</p> <p>As per the Disenrollment Process Flow Chart / the State Specific Collaborative process with Maximus LHCC submits Members for disenrollment through LaMeds Reporting (via OMNI) for Dates of Death and Out of State address confirmed. If a member is requesting disenrollment, the member is transferred to the Medicaid Office CSR line for processing through the Maximus tracking system. The report attached in the file labelled LHCC Initiated Disenroll LaMeds Communication And Member Examples (on the tab labelled Report LaMeds DOD and OOS 2024) includes tracking of date submitted to LDH (Column H), Time submitted to LDH (Column I), Request type including details on the Date of Death or the Out of State Address reported through this data feed (Column E), Receiver (State/ LaMeds) Response</p>		



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<p>(Column Q). In addition to the 2024 Report data, there is additional Tabs within this report showing examples of how (after LaMeds is finished processing the data) that data is then sent through Maximus back to the MCO (LHCC) to finalize the disenrollment.</p> <p>For other types of disenrollments outside of DOD/OOS (i.e., member requests that flow through Maximus). I cannot pull a 12mo report on these as they flow through the Maximus system (not the MCO system). I have included screenshots within that VPN of current case tasks / member case examples within the file labelled Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots.</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>• Disenrollment Policy – <a href="#">LA.ELIG.02</a> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• State Specific Workflow Documents:               <ul style="list-style-type: none"> <li>○ Disenrollment Process Flow Chart</li> </ul> </li> <li>• Report of MCE (LHCC Initiated) requests: LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label Report LaMeds DOD and OOS 2024</li> </ul> <p>Maximus State Specific Workflow and Case Examples: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</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><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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• <a href="#">LA.ELIG.02</a> ; Page 1 &amp; 2 Sections A &amp; B</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>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) 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>	<ul style="list-style-type: none"> <li>Disenrollment Process Flow Chart</li> <li>Disenrollment Process Training Document – Out of State and Date Of Death Reported updates</li> <li>Technical Manual Maximus Medical Companion Guide (See Appendix D Excerpt for Full list of Disenrollment Codes), (See page 17 highlighted section for code processing logic)</li> <li>Maximus Guide – Disenrollment Tasks Procedure – Plans</li> <li>LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label OOS Disenroll Example 2</li> <li>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>a. “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>Note this is achieved by limiting the requests processed through the MCO level. LHCC only feeds over PHI updates to Date of Death or Out of State Address changes. These PHI update will result in a disenrollment once processed by LDH/LaMeds and the update is fed back through the 834 data files. See Case Example OOS Disenroll Example 2 Tab on file name LHCC Initiated Disenroll LaMeds Communication And Member Examples for an example of an Out of State Address PHI update resulting in a member disenrollment.</p> <p>The State Reviews / Forms – are processed not at the MCO level, but rather these are processed through the Enrollment Broker Maximus. This system Tracks the reason for request as well as allows the MCO to offer feedback on the request; however, after feedback is submitted the State renders the final decision. LHCC cannot access reports on the disenrollment reasons processed through Maximus, At the MCO level we see the task when it is fed to us through the Enrollment Broker’s VPN system. After we respond within that VPN system, the feedback is forwarded to the State and the “Task” is removed from the MCO’s Queue.</p> <ul style="list-style-type: none"> <li>See file Name Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</li> </ul>		



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<ul style="list-style-type: none"> <li>○ Tab Information on Process – has a high level infographic on how this data flows through the Enrollment Broker with the MCO as a secondary feedback support</li> <li>○ Tab VPN High Level Screenshot – has a screenshot of the Disenrollment Queue managed by Maximus</li> <li>○ 5 Additional Tabs – Labelled Member Requesting Disenrollment – contain screenshots of current disenrollment Tasks awaiting MCO feedback within the Queue (these tasks include the date request was made, the for cause reason, and Member data, and IF supporting documentation is available it will also be attached to the task). Currently none of the Disenrollment request tasks have supporting documentation submitted by the member. LHCC is unable to pull historical tasks/data as the system is within the Enrollment Broker (Maximus’) VPN Secure Environment. Any reporting or exports would be managed by them.</li> </ul> <p>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) 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</p> <p>As outlined in LA.Elig.02 page 1&amp;2 section A &amp; B – LHCC does not make determinations on disenrollment or in CSOC status. CSOC is managed by the designee Magellan – who communicates the enroll/disenroll dates of CSOC services to LDH / Maximus. CSOC Spans are communicated to the MCOs via the 834 Eligibility Files. Disenrollment Decisions all flow through the State / Enrollment Broker. If the State determines a member is no longer eligible for Medicaid or approves a transfer to another MCO – the Disenrollment is sent over as a 024 Maintenance Code via the 834 Eligibility data files. The MCO guide to processing these files is the Technical Manual from Maximus called the Medical Companion Guide. I’ve included the full guide with references to the programming sections below</p> <ul style="list-style-type: none"> <li>○ Excerpt Technical Manual Maximus Medical Companion Guide- Disenrollment Codes – Excerpt Appendix D of Technical Manual -Medical Companion Guide</li> <li>○ Full Technical Manual Maximus Medical Companion Guide – Medical Companion Guide (See Appendix D Excerpt for Full list of Disenroll Codes), (See page 17 highlighted section for code processing logic)</li> </ul> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>● Disenrollment Policy – <u>LA.ELIG.02</u> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>● Staff Training Materials:               <ul style="list-style-type: none"> <li>○ Disenrollment Process Flow Chart</li> <li>○ Disenrollment Process Training Document – Out of State and Date Of Death Reported updates</li> </ul> </li> </ul>		



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<ul style="list-style-type: none"> <li>○ Excerpt Technical Manual - Disenrollment Codes – Excerpt Appendix D of Technical Manual -Medical Companion Guide</li> <li>○ Full Technical Manual – Medical Companion Guide (See Appendix D)</li> <li>○ Technical Manual - Maximus Guide – Disenrollment Tasks Procedure – Plans</li> <li>● Case Example: LHCC Initiated Disenroll LaMeds Communication And Member Examples ; Tab Label OOS Disenroll Example 2</li> <li>● Maximus Case Example: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</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.		
Disenrollment Requested by the Member		
<p>4. The member may request disenrollment from the MCE as follows:</p> <p>a. Without cause, at the following times:</p> <p>MCO:</p> <ul style="list-style-type: none"> <li>i. During the disenrollment period offered to Enrollees at the start of the contract.</li> <li>ii. 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.</li> <li>iii. At least once every 12 months thereafter (during the enrollment period).</li> <li>iv. At least once every 12 months thereafter.</li> <li>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.</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>● LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>● Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</li> <li>● Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</li> <li>● Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<ul style="list-style-type: none"> <li>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.</li> <li>vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</li> </ul> <p>PAHP:</p> <ul style="list-style-type: none"> <li>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.</li> <li>ii. At least once every 12 months thereafter.</li> <li>iii. 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.</li> <li>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.</li> <li>v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722.</li> </ul>		



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<p style="text-align: center;">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></p> <p>As highlighted in previous MCE Process notes, The member makes the request for (Without Cause) Disenrollment to the entity that Manages the Tracking and processing of Disenrollment requests. That entity is the Enrollment Broker Maximus. See the Member Materials File -- <u>Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment and page 5 Sections “Disenrolling For Cause” &amp; “How to Disenroll”</u> for member process for requesting disenrollment.</p> <p>Once member has requested Disenrollment this goes through Maximus as per outlined in the file Name Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</p> <ul style="list-style-type: none"> <li>○ Tab Information on Process – has a high level infographic on how this data flows through the Enrollment Broker with the MCO as a secondary feedback support</li> <li>○ Tab VPN High Level Screenshot – has a screenshot of the Disenrollment Queue managed by Maximus</li> <li>○ 5 Additional Tabs – Labelled Member Requesting Disenrollment – contain screenshots of current disenrollment Tasks awaiting MCO feedback within the Queue (these tasks include the date request was made, the for cause reason, and Member data, and IF supporting documentation is available it will also be attached to the task). Currently none of the Disenrollment request tasks have supporting documentation submitted by the member. LHCC is unable to pull historical tasks/data as the system is within the Enrollment Broker (Maximus’) VPN Secure Environment. Any reporting or exports would be managed by them.</li> </ul> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>○ Disenrollment Policy – <u>LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</u></li> <li>○ Member Materials -- <u>Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</u></li> <li>○ Member Materials -- <u>Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</u></li> <li>○ Member Materials -- <u>Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</u></li> </ul>		



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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.		
Procedures for Disenrollment		
<p>5. The following are causes for disenrollment:</p> <p>MCO:</p> <ol 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> </ol>	<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>• LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</li> <li>• Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</li> <li>• Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<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> <li>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;</li> <li>c. Poor quality of care;</li> <li>d. Lack of access, or lack of access to providers experienced in dealing with the member’s specific needs;</li> <li>e. The Contract between the MCE and LDH is terminated;</li> <li>f. Any other reason deemed to be valid by LDH and/or its agent.</li> </ul> <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></p> <p>As highlighted in previous MCE Process notes, The member makes the request for cause Disenrollment to the entity that Manages the Tracking and processing of Disenrollment requests. That entity is the Enrollment Broker Maximus. See the Member Materials File -- <u><a href="#">Member Materials Member Handbook Screenshots</a></u>; Page 4 Section “Disenrollment and page 5 Sections “Disenrolling For Cause” &amp; “How to Disenroll” for member process for requesting disenrollment.</p> <p>Once member has requested Disenrollment this goes through Maximus as per outlined in the file Name Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</p>		



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<ul style="list-style-type: none"> <li>○ Tab Information on Process – has a high level infographic on how this data flows through the Enrollment Broker with the MCO as a secondary feedback support</li> <li>○ Tab VPN High Level Screenshot – has a screenshot of the Disenrollment Queue managed by Maximus</li> <li>○ 5 Additional Tabs – Labelled Member Requesting Disenrollment – contain screenshots of current disenrollment Tasks awaiting MCO feedback within the Queue (these tasks include the date request was made, the for cause reason, and Member data, and IF supporting documentation is available it will also be attached to the task). Currently none of the Disenrollment request tasks have supporting documentation submitted by the member. LHCC is unable to pull historical tasks/data as the system is within the Enrollment Broker (Maximus’) VPN Secure Environment. Any reporting or exports would be managed by them.</li> </ul> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>○ Disenrollment Policy – LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>○ Member Materials -- Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</li> <li>○ Member Materials -- Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</li> <li>○ Member Materials -- Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</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>6. The member must request disenrollment by submitting an oral or written request (as required by the State):</p> <ul style="list-style-type: none"> <li>a. To the State or its agent; or</li> <li>b. To the MCE, if the State permits MCEs to process disenrollment requests.</li> </ul> <p style="text-align: right; margin-right: 100px;">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>	<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>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</li> <li>• Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</li> <li>• Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</li> <li>• Disenrollment Process Flow Chart</li> <li>• Maximus Guide – Disenrollment Tasks Procedure</li> <li>• LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> <li>• Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5)</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>As outlined in the Member Handbook the member must submit requests for disenrollment to the State Medicaid Office see the member materials file -- Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”. Examples of Members requesting Disenrollment through the designated Enrollment Broker Maximus are housed within file name: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5).</p> <p>For LHCC data updates resulting in a disenrollment you can see the 4 Examples within – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll or OOS Disenroll Examples 1-4).</p> <p>LHCC is not permitted to disenroll (or make decisions about who will be disenrolled). Disenrollment direction to the MCO – arrives via the 834 file after Maximus and LDH have made their final determinations. See Maximus Guide – Disenrollment Tasks Procedure (Page 8 – all tasks are forwarded to LDH for final determination either automatically OR after feedback is offered by the MCO)</p>		



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Requirement	Supporting Documentation	Score
<p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>• Disenrollment Policy – LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Member Materials -- Member Materials Member Handbook Screenshots; Page 3 Section “Open Enrollment”</li> <li>• Member Materials -- Member Materials Member Handbook Screenshots; Page 4 Section “Disenrollment”</li> <li>• Member Materials -- Member Materials Member Handbook Screenshots; Page 5 Section “Disenrolling For Cause” &amp; “How to Disenroll”</li> <li>• MCO vs State Specific Workflow Documents:               <ul style="list-style-type: none"> <li>○ Disenrollment Process Flow Chart</li> <li>○ Maximus Guide – Disenrollment Tasks Procedure</li> </ul> </li> <li>• 4 Examples Member LHCC Initiated Disenrollments – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> <li>• 5 Examples Maximus Managed Member Requested Disenrollments: File name: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5)</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. 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>• <u>LA.ELIG.02</u> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Disenrollment Process Flow Chart</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Maximus Guide – Disenrollment Tasks Procedure</li> <li>LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> <li>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5)</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>LHCC is not permitted to disenroll (or make decisions about who will be disenrolled). Disenrollment direction to the MCO – arrives via the 834 file after Maximus and LDH have made their final determinations. See Maximus Guide – Disenrollment Tasks Procedure (Page 8 – all tasks are forwarded to LDH for final determination either automatically OR after feedback is offered by the MCO).</p> <p>Due to Disenrollment final decisions residing with the State, and due to the Disenrollment requests being managed by Maximus and housed within the Maximus VPN system – Member Letters are not sent by LHCC. LHCC does not have line of sight into the determination until after the final disenrollment code is sent to process the disenrollment via the 834 file (after the fact).</p> <p>As outlined in the Member Handbook the member must submit requests for disenrollment to the State Medicaid Office see the member materials file -- <u>Member Materials Member Handbook Screenshots</u>; Page 5 Section “How to Disenroll”. Examples of Members requesting Disenrollment through the designated Enrollment Broker Maximus are housed within file name: <u>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</u> (Tabs Labelled Member Requesting Disenroll 1-5).</p> <p>For LHCC data updates resulting in a disenrollment you can see the 4 Examples within – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll or OOS Disenroll Examples 1-4).</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>○ Disenrollment Policy – <u>LA.ELIG.02</u> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>○ MCO vs State Specific Workflow Documents:             <ul style="list-style-type: none"> <li>▪ Disenrollment Process Flow Chart</li> <li>▪ Maximus Guide – Disenrollment Tasks Procedure</li> </ul> </li> </ul>		



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Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>○ 4 Examples Member LHCC Initiated Disenrollments – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> <li>○ 5 Examples Maximus Managed Member Requested Disenrollments: File name: <u>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots</u> (Tabs Labelled Member Requesting Disenroll 1-5)</li> </ul>		
<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>		
Use of the MCE's Grievance Process		
<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>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>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;">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>• LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Disenrollment Process Flow Chart</li> <li>• Maximus Guide – Disenrollment Tasks Procedure</li> <li>• LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5)</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>LHCC is not permitted to disenroll (or make decisions about who will be disenrolled). Disenrollment direction to the MCO – arrives via the 834 file after Maximus and LDH have made their final determinations. See Maximus Guide – Disenrollment Tasks Procedure (Page 8 – all tasks are forwarded to LDH for final determination either automatically OR after feedback is offered by the MCO).</p> <p>Due to Disenrollment final decisions residing with the State, and due to the Disenrollment requests being managed by Maximus and housed within the Maximus VPN system – Member Letters are not sent by LHCC. LHCC does not have line of sight into the determination until after the final disenrollment code is sent to process the disenrollment via the 834 file (after the fact).</p> <p>As outlined in the Member Handbook the member must submit requests for disenrollment to the State Medicaid Office see the member materials file -- Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”. Examples of Members requesting Disenrollment through the designated Enrollment Broker Maximus are housed within file name: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5).</p> <p>For LHCC data updates resulting in a disenrollment you can see the 4 Examples within – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll or OOS Disenroll Examples 1-4).</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>Disenrollment Policy – LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>MCO vs State Specific Workflow Documents:               <ul style="list-style-type: none"> <li>Disenrollment Process Flow Chart</li> <li>Maximus Guide – Disenrollment Tasks Procedure</li> </ul> </li> <li>4 Examples Member LHCC Initiated Disenrollments – File Name: LHCC Initiated Disenroll LaMeds Communication And Member Examples (Tabs Labelled DOD Disenroll Example 1-4)</li> <li>5 Examples Maximus Managed Member Requested Disenrollments: File name: Tracking Member Initiated Requests Maximus VPN Disenrollment Request Screenshots (Tabs Labelled Member Requesting Disenroll 1-5)</li> </ul>		



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Requirement	Supporting Documentation	Score
<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>		
<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; margin-right: 50px;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”</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></p> <p>Disenrollment determinations are made by the state. Maximus tracks MCO feedback on Disenrollment Feedback to forward to the State but the end determination is made by LDH.</p> <p>See Policy LA.Elig.02 page 1 section A and member Handbook excerpt via the member materials file -- <a href="#">Member Materials Member Handbook Screenshots</a>; Page 5 Section “How to Disenroll”.</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>Disenrollment Policy – LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>Member Materials -- Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”</li> </ul>		
<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>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<b>Enrollment</b>		
<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 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>PIHP:</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><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>• LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>• Technical Manual Maximus Medical Companion Guide (See Appendix D Excerpt for Full list of Disenrollment Codes), (See page 17 highlighted section for code processing logic)</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 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>		
<p><b>MCE Description of Process:</b>            LHCC enrollment and disenrollment is not determined by the MCO. Enrollment is set based on the data submitted to LHCC by the Enrollment Broker Maximus. This data is ingested per the direction of Maximus via the Technical Manual – the file named Medical Companion Guide (See page 17). Page 17 outlines the codes that dictate adding a member (enrolling), terming a member (disenroll), or changing a member (updating demographics).</p> <ul style="list-style-type: none"> <li>○ 021 code = add a member</li> <li>○ 024 code = term a member</li> <li>○ 001 code = update a member</li> </ul> <p>LHCC ingests this data from the enrollment broker. Any updates to our systems data relies on the communication / file data from the Enrollment Broker.</p> <p><b>Summation of evidence</b></p> <ul style="list-style-type: none"> <li>● Disenrollment Policy – <a href="#">LA.ELIG.02</a> ; Page 1 &amp; 2 Sections A &amp; B</li> <li>● Full Technical Manual – Medical Companion Guide (See page 17)</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 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>● LA.ELIG.02 ; Page 1 &amp; 2 Sections A &amp; B</li> <li>● Member Materials Handbook Excerpts Antidiscrimination (page 1)</li> </ul>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Technical Manual Maximus Medical Companion Guide (page 17)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.MBRS.25_Member_Rights_and_Responsibilities (identified in virtual review)</li> </ul>	
<p><b>MCE Description of Process:</b></p> <p>LHCC outlines our Antidiscrimination policies and stance – see file “Member Materials Handbook Excerpts Antidiscrimination” (Page 1 of this file is a screenshot of the antidiscrimination member facing notice and how members can file a complaint if necessary). The antidiscrimination member educational material is printed in English, Spanish, French, and Vietnamese. All notices are included within that excerpt file.</p> <p>LHCC also does not make determinations for disenrollment per LA.ELIG.02 page 1 section A and the “Disenrollments Process Flow Chart”. Enrollment and Disenrollment is dictated by LDH determination and communicated to LHCC by the Enrollment Broker (Maximus) via the 834 file. This file communicates the action using a Maintenance Code as outlined in the “Technical Manual Maximus Medical Companion Guide” page 17 highlighted section which states “Only 021 and 024 transactions should be used to add or update dates.” An 021 is the Enrollment (Add) code and the 024 is the Disenrollment (Term) code within the data file.</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>Disenrollment Policy – LA.ELIG.02 ; Page 1 Section A</li> <li>Technical Manual Maximus Medical Companion Guide (page 17)</li> <li>Member Materials -- Member Materials Handbook Excerpts Antidiscrimination (page 1)</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>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><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>	<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>MCO:</p> <p>a. The notice shall include:</p> <p style="margin-left: 20px;">i. The reason for the disenrollment;</p> <p style="margin-left: 20px;">ii. The effective date of the disenrollment;</p> <p style="margin-left: 20px;">iii. An instruction that the Enrollee choose a new MCO; and</p> <p style="margin-left: 20px;">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.</p> <p>PAHP:</p> <p>a. The notice shall include:</p> <p style="margin-left: 20px;">i. The reason for the disenrollment;</p> <p style="margin-left: 20px;">ii. The effective date;</p> <p style="margin-left: 20px;">iii. An instruction that the enrollee choose a new DBPM; and</p> <p style="margin-left: 20px;">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.</p> <p style="text-align: right; margin-right: 20px;">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>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.ELIG.02 ; Page 1 &amp; 2 Sections A</li> <li>Disenrollment Process Flow Chart</li> <li>Maximus Guide – Disenrollment Tasks Procedure</li> <li>Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC does not send notices of disenrollment or proposed disenrollment – proposals for disenrollment flow through Maximus (the Enrollment Broker) and the State Medicaid Office (this in practice means that LHCC is only able to offer feedback to tasks within the Maximus system (not see or receive notice in advance if a disenrollment task was approved).</p> <p>Policy LA.Elig.02 page 1 section A and the Member Materials file (Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”) illustrates that the member is directed to state for member initiated disenrollment requests.</p>		



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Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	Supporting Documentation	Score
<p>Member notifications are either managed by Maximus or LDH Medicaid Office – as the party making the determination and with visibility into if a member will be enrolled or disenrolled in the future (LHCC only sees the data once the member is formally being enrolled or disenrolled, not in advance of that determination).</p> <p>Summation of Evidence</p> <ul style="list-style-type: none"> <li>○ Disenrollment Policy – LA.ELIG.02 ; Page 1 Section A</li> <li>○ MCO vs State Specific Workflow Documents:               <ul style="list-style-type: none"> <li>▪ Disenrollment Process Flow Chart</li> <li>▪ Maximus Guide – Disenrollment Tasks Procedure</li> </ul> </li> <li>○ Member Materials -- Member Materials Member Handbook Screenshots; Page 5 Section “How to Disenroll”</li> </ul>		
<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 develop a letter notification template for use in the event it would request involuntary disenrollment and need to notify the member.</p>		
<p><b>Required Actions:</b> No action required.</p>		

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>	



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**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>• LA.MBRS.25 Member Rights and Responsibilities_10.10.23 -Policy &amp; Procedure Sections Pg. 1-2</li> <li>• LA.MBRS.25 Member Rights and Responsibilities_08132024 -Policy &amp; Procedure Sections Pg. 1-2</li> <li>• CC.COMP.PRVC.10_ - Individual Rights to Protected Health Information - Pg. 2-6</li> <li>• LA Healthcare Connections Provider Manual 12.2023 -Pg. 71-72</li> <li>• LA Healthcare Connections Provider Manual 4.2024 - Pg. 72-73</li> <li>• LA Healthcare Connections Provider Manual-12.2024 Pg. 72-73</li> <li>• MCO_Manual 8.15.24 Pg. 232-233</li> <li>• CC.COMP.PRVC.05_-Privacy_Notice-Content_and_Provision_of_Notice Pg. 2-3</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 attached documentation demonstrates our compliance with contractual and regulatory requirements regarding member rights. Specifically, it includes written policies that outline our commitment to protecting member rights, ensuring access to</p>		



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
<p>care, and promoting dignity, respect, and informed decision-making. These policies are reviewed and updated regularly to remain aligned with applicable standards and best practices. Included in the evidence for this item are the Member Rights and Responsibilities policies that were in effect during the evaluation period, CY 2024. Additionally, we are including the Individual Rights to PHI policy as well as the Provider Manuals in effect during the evaluation period, CY 2024. The Provider Manual underwent three (3) updates that impact this audit. Also applicable to this item are the MCO manual and the policy related to issuing the privacy notice.</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 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>	<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>• 2024 Compliance Privacy and Confidentiality §4.2 (pdf p. 17); §4.3 (pdf p. 18); §5.4 (pdf p. 20-22); §15.5 (pdf p. 22); §5.11 (pdf p. 27-28)</li> <li>• BH New Provider Orientation (Updated 11-23-24) Training Pg. 41-43, Support for your Practice Pg. 53-54</li> <li>• Grievances Universe Template</li> <li>• LA Healthcare Connections Provider Manual 12.2023 Pg. 71-72</li> </ul>	



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Standard II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LA Healthcare Connections Provider Manual 4.2024 Pg. 72-73</li> <li>LHCC-keys-to-compliance-for-new-employees, – p. 43, 51-52.</li> <li>PH New Provider Orientation Training Our Website Pg. 11, Provider Responsibilities Pg. 54</li> <li>Provider Contract Agreement Template Section 2.4 Provider Manual: Policies_and_Procedure Pg. 3-4</li> <li>Provider Visits Record- BH with training tab Provider Education_and_Training: Information_Provided Pg. 2</li> <li>Provider Visits Record- PH with training tab</li> <li>Provider Education_and_Training: Information_Provided Pg. 2</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the requirement to maintain written policies that safeguard member rights. These policies clearly articulate our commitment to ensuring that all members are treated with dignity, respect, and fairness. Furthermore, we ensure that both our employees and contracted providers are informed of and adhere to these policies through ongoing training, oversight, and contractual obligations. This approach supports consistent protection of member rights across all levels of service delivery. The LHCC Provider Manuals included were in effect during the review period (CY 2024). The manual that was in effect in January 2024 is the 2023 version updated on 12/2023. The manual was updated in April 2024, and that document is included in the evidence. Finally, the manual was updated again in December 2024; therefore, that document is also included in the evidence folder.</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>Specific Rights</b>		
<p>3. The MCE complies with the requirements listed in the Member Rights Checklist.</p> <p style="text-align: right;">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> <li>• HSAG will also use the results of the Member Rights Checklist</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LHCC Member Handbook - Pgs. 29, 42, 60, 69, 83</li> <li>• LA.MBRS.25_Member_Rights_and_Responsibilities_08132024- Pg. 2</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Discuss checklist and decide.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<b>General Rule</b>		
<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><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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<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;">42 CFR §438.224            42 CFR §457.1110            45 CFR §164.530            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>• 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> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.01 - Privacy Program Description, pg. 3-4</li> <li>• LA.COMP.100_Compliance_Program_Descripti on_2.6.24, p. 7, 11-12</li> <li>• CC.INFOSEC.09.04 - _Information_Classification,_Data_Protection_a nd_Media_Handling_Policy_Rev 11-2024, Sections – Definitions (p.1), 2.4 Data Integrity and Monitoring (p.4), 3.4 Security of System Documentation (p. 5).</li> <li>• CC.INFOSEC.09.04 - _Information_Classification,_Data_Protection_a nd_Media_Handling_Policy_Rev 07-2024, Sections – Definitions (p.1), 2.4 Data Integrity and Monitoring (p.4), 3.4 Security of System Documentation (p. 5).</li> <li>• HIPAA Security Assessment – Business Unit Questionnaire – 2024 LA144 Covington 9-2024, Section 1-3; 7, 10</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>HIPAA Security Assessment - Business Unit Questionnaire - 2024 LA4171 Baton Rouge 9-2024, Section 1-3; 7, 10</li> <li>2024 Compliance Privacy and Confidentiality, §2.3 p. 9-11; §3.1 p. 12-13; §5.4 p. 20-22</li> <li>LHCC-keys-to-compliance-for-new-employees, p. 10</li> <li>Executed Provider Agreement, §2.4, p. 3-4, §2.14 p.5</li> <li>LA Healthcare Connections Provider Manual 12.2023 Pg. 114-120</li> <li>LA Healthcare Connections Provider Manual 4.2024 Pg. 113-119</li> <li>LA Healthcare Connections Provider Manual-12.2024 Pg. 113-119</li> <li>2024 Centene Code Of Conduct, p.25</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule, as outlined in 45 CFR Parts 160 and 164, Subparts A and E. Specifically, we maintain and enforce policies and procedures that govern the use and disclosure of individually identifiable health information. These policies are designed to ensure that all such information is handled in accordance with federal privacy standards, protecting confidentiality, integrity, and availability of protected health information (PHI). Our workforce members and business associates are trained and held accountable for adhering to these requirements. The LHCC Provider Manuals included were in effect during the review period (CY 2024). The manual that was in effect in January 2024 is the 2023 version updated on 12/2023. The manual was updated in April 2024, and that document is included in the evidence. Finally, the manual was updated again in December 2024; therefore, that document is also included in the evidence folder.</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>Use and Disclosure of PHI</b>		
<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> <li>f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g).</li> </ol> <p style="text-align: right; margin-right: 20px;">           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)         </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></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.04- Assurances_from_Business_Associates_to_Safeguard_Protected_Health_Information. Pg. 3-4</li> <li>• BAA 2023 Template Pg. 2-7</li> <li>• MediTrans_BAA Pg. 2-5, Section 3 and 4</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;">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>		
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the Privacy Rule, specifically the requirements outlined in the Rule. We ensure that our business associates do not use or disclose protected health information (PHI) except as permitted or required by the Rule and their respective agreements. All business associate agreements include provisions that require appropriate safeguards for PHI and restrict its use and disclosure to purposes directly related to the services provided on our behalf. We are providing a BAA template that is the template used during the review period (CY 2024) as well as an example of an executed BAA with our transportation vendor.</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="padding-left: 20px;">a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528.</p> <p style="padding-left: 20px;">b. When required by the Secretary to investigate or determine the MCE’s compliance with 45 CFR §160 subpart C.</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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p style="text-align: right;">45 CFR §164.502(a)(2-4)            45 CFR §164.524            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>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.04- Assurances from Business Associates to Safeguard Protected Health Information. Pg. 3-4</li> <li>• BAA 2023 Template Pg. 2-7</li> <li>• MediTrans BAA Pg. 2-5, Section 3 and 4</li> </ul>	



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Requirement	Supporting Documentation	Score
	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>• MSPS.24 MP Call Audit and Quality Criteria and Protocol</li> <li>• Caller Identity Verification</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the Privacy Rule, specifically the requirements outlined in the Rule. We ensure that our business associates do not use or disclose protected health information (PHI) except as permitted or required by the Rule and their respective agreements. All business associate agreements include provisions that require appropriate safeguards for PHI and restrict its use and disclosure to purposes directly related to the services provided on our behalf. We are providing a BAA template that is the template used during the review period (CY 2024) as well as an example of an executed BAA with our transportation vendor.</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>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>HSAG Required Evidence:</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.09- Disclosing and Requesting Only the Minimum Amount of PHI Necessary Pg. 1-2</li> <li>• CC.COMP.PRVC.10- Individual_Rights_to_Protected_Health_Information, Pg. 4</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>2024 Compliance Privacy and Confidentiality Pg. 12-14 Section 3</li> <li>CC.INFOSEC.01.00 - Identity and Access Management Policy, Section 1 Access Control (p. 2)</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule’s minimum necessary standard, as outlined in the Privacy rule. We have established and implemented policies and procedures to ensure that any use or disclosure of protected health information (PHI) to other covered entities or business associates is limited to the minimum amount necessary to accomplish the intended purpose. These safeguards include role-based access controls and regular workforce training to reinforce appropriate handling of PHI in accordance with federal privacy 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>		
<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;">45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a)</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>CC.COMP.PRVC.09- Disclosing and Requesting Only the Minimum Amount of PHI Necessary Pg. 1-3</li> <li>2024 Compliance Privacy and Confidentiality - Section 4.1-4.4, 5.2</li> <li>LHCC-keys-to-compliance-for-new-employees, - Lesson 6</li> <li>CC.COMP.PRVC.11- Allowable Disclosures - Pg 3-5, 7, 11</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;">45 CFR Part 160 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>		
<b>MCE Description of Process:</b> Same as #7 above.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<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 the 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/> <ul style="list-style-type: none"> <li>• Evidence as Submitted by the MCE:</li> <li>• 2024 Compliance Privacy and Confidentiality Pg. 13-14 Section 3.2 Covered Entities and Pg. 17 Section 4.2 Obtaining Authorizations</li> <li>• CC.COMP.PRVC.03- Authorization_and_Revocation_of_Protected_Health_Information- Pg. 2-5</li> <li>• LHCC-keys-to-compliance-for-new-employees, Pg. 43</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>Permission to Share my Information (Authorization Form)</li> <li>Authorization of Disclosure Example 1</li> <li>Authorization of Disclosure Example 2</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Web Support A User - Medicaid</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the requirements regarding the use and disclosure of protected health information (PHI). Specifically, it confirms that we obtain a valid, signed authorization from the individual prior to disclosing PHI, except where permitted or required by law without authorization. Our policies and procedures ensure that authorizations are properly 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>		
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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.05- Privacy Notice - Content and Provision of Notice – Pg.1</li> <li>• CC.COMP.PRVC.10- Individual Rights to Protected Health Information – Pg. 4-5</li> <li>• 2024 Compliance Privacy and Confidentiality Pg. 13-14 Section 3.2 Covered Entities and Pg. 17 Section 4.2 Obtaining Authorizations</li> <li>• LHCC-keys-to-compliance-for-new-employees, Pg. 43-44</li> <li>• HIPAA Revocation of Authorization to Disclose PHI Template</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Attestation that no requests were received in 2024.</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule, which grants individuals the right to request restrictions on the use and disclosure of their protected health information (PHI). Our policies and procedures allow members to request such restrictions, and we evaluate and document each request in accordance with regulatory 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>		
<p>11. The MCE complies with the member’s right to access PHI and the requirements under 45 CFR §164.524.</p> <p>a. The MCE acts on a request for access no later than 30 days after receipt of the 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> </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 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;">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>	<ul style="list-style-type: none"> <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></p> <ul style="list-style-type: none"> <li>CC.COMP.PRVC.10- Individual_Rights_to_Protected_Health_Information Pg. 6-7</li> <li>2024 Compliance Privacy and Confidentiality Pg. 12-14 Section 3 PHI, Covered Entities, and More</li> <li>LHCC-keys-to-compliance-for-new-employees, Pg. 43-44</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Attestation that no requests were received in 2024.</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule, which grants individuals the right to access their protected health information (PHI). Our policies and procedures ensure that members are able to submit requests to inspect or obtain a copy of their PHI maintained in a designated record set. We have established processes to verify, document, and respond to these requests in a timely manner.</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>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;">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 @ send email to timely completion of the amendment request</li> <li>• One example of a denial of an amendment and notification to the member</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.10- Individual Rights to Protected Health Information – Pg. 2, 9, 10, 11</li> <li>• 2024 Compliance Privacy and Confidentiality Pg. 17-18 Section 4.2 Obtaining Authorization</li> <li>• LHCC-keys-to-compliance-for-new-employees, Pg. 43-44</li> <li>• Request_for_Amendment_of_Health_Information_Form</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Attestation that no requests were received in 2024.</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 attached evidence demonstrates our compliance with the HIPAA Privacy Rule, which grants individuals the right to request an amendment to their protected health information (PHI) maintained in a designated record set. Our policies and procedures</p>		



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Requirement	Supporting Documentation	Score
<p>allow members to submit amendment requests. Neither LDH nor LHCC permits members to directly update their demographic information through written communication or other means. The 834 file serves as the sole source of truth for all member demographic data. LHCC may only update member demographic information in our systems upon receipt of an updated 834 file. When a member contacts LHCC to request a demographic change, it is treated solely as a request. This request is submitted to LDH via the LaMeds API for review. If LDH determines that an update is appropriate, the change is reflected in a subsequent 834 file. LHCC then updates its internal records based on the information provided in that file.</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>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. 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>	<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> <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><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>• CC.COMP.PRVC.10- Individual_Rights_to_Protected_Health_Information - Pg. 4, 11</li> <li>• CC.COMP.PRVC.05- Privacy_Notice_-_Content_and_Provision_of_Notice – Pg. 3</li> <li>• HIPAA Privacy Incident Form</li> <li>• Accounting of Disclosure by Name and ID Number</li> <li>• Request for an Accounting of Disclosures of Protected Health Information (PHI)</li> <li>• Response to Request for an Accounting of Disclosures of Protected Health Information (PHI)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Attestation that no requests were received in 2024.</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule, specifically, which grants individuals the right to request an accounting of certain disclosures of their protected health information (PHI). Our policies and procedures allow members to submit such requests and ensure that we provide a timely, written accounting of applicable disclosures. We maintain appropriate documentation and tracking mechanisms to support this process and meet all regulatory 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>		



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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="padding-left: 20px;">a. Breach and unsecured PHI are as defined in 45 CFR §164.402.</p> <p style="text-align: right; padding-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> <ul style="list-style-type: none"> <li>CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process, Pg. 1-3,</li> <li>HIPAA Privacy Incident Form</li> <li>Breach Notice Template</li> <li>LHCC Privacy Incident Workflow</li> <li>List of Breaches</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 attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of 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>		



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<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 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>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</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</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process, Pg. 1</li> <li>• HIPAA Privacy Incident Form</li> <li>• LHCC Privacy Incident Workflow</li> <li>• List of Breaches</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 attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of 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>		



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<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;">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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Uses/Disclosures and Privacy Breaches; and Breach Notification Process – Page 2</li> <li>• LHCC Business Unit Privacy- Security Incident Reporting Requirements</li> <li>• Individual Breach Notice BP</li> <li>• Individual Breach Notice RR</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 attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of 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>		



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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> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process - Pg. 3</li> <li>• Breach Notice Template</li> <li>• Individual Breach Notice BP</li> <li>• Individual Breach Notice RR</li> <li>• LHCC does not have notification to media outlets as this requirement was not triggered during the review period.</li> <li>• HIPAA Breach Letter_Reading Level Example_Jan2024</li> <li>• <a href="#">MMECompanionGuide.pdf</a>, Reading Level section, p. 12-13</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 attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of member privacy.</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.		
<p>18. The notification must be provided in the following form:</p> <p>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.</p> <p>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.</p> <p>c. The notification may be provided in one or more mailings as information is available.</p> <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> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process- Pg. 3-4</li> <li>• First-Class mailing statement – unavailable</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of member privacy. However, we do not have documentation to evidence that we sent member notifications via first class mail.</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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<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>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>b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must:</p> <p>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>ii. Include a toll-free phone number that remains active for at least 90 days where an individual can learn 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>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> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process – Pg. 3-4</li> <li>• Substitute notice was not applicable during evaluation period.</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> The attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of member privacy. While we do have processes in place to demonstrate our compliance with timely breach notifications; however, we did not have instances during CY 2024 where substitute notice was required.</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>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> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process – Pg. 3</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> The attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of member privacy. However, we did not have instances during CY 2024 where urgent notification because of possible imminent misuse of unsecure PHI was at risk.</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>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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process – Pg. 2-3</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of 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>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</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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>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>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process – Pg. 3</li> <li>List of Breaches</li> <li>CMS Report DB-3262599</li> <li>CMS Report DB- 3265840</li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Breach Notification Rule. We have established and implemented policies and procedures to promptly identify, investigate, and address breaches of unsecured protected health information (PHI). These procedures include conducting a risk assessment, documenting findings, and notifying affected individuals, the Louisiana Department of Health (LDH), and the U.S. Department of Health and Human Services (HHS), as appropriate. Our approach ensures timely and compliant breach response and supports the protection of member privacy. For the Change Healthcare breach in 2024, all member notifications were mailed by UHC. Change Healthcare is in the process of completing the OCR notification. They received an agreement from the OCR that they can complete the OCR notice after the member notices were completed.</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><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> </ul>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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<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 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>	<ul style="list-style-type: none"> <li>• One example of executed business associate agreement</li> <li>• One example of executed subcontractor contract</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.04- Assurances_from_Business_Associates_to_Safeguard_Protected_Health_Information. – Pg. 3-4</li> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process</li> <li>• In the regular course of business, we do not have examples of executed subcontractor contracts.</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with HIPAA requirements related to breach notification by business associates, as outlined in the Rule. Our policies and procedures require all business associates to promptly report any suspected or confirmed breaches of unsecured protected health information (PHI). These procedures include timely investigation, documentation, and notification to us, enabling appropriate follow-up and reporting to affected individuals and regulatory agencies, as required. Business associate agreements include specific provisions outlining these responsibilities to ensure accountability and 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>		
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©.</p> <p style="text-align: right;">45 CFR §164.520(a)(1)            45 CFR §164.520(b)(1)            45 CFR §164.520©            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>• <a href="#">Link to Notice of Privacy Practices on the MCE’s website</a></li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.05- Privacy_Notice_-_Content_and_Provision_of_Notice – Pg 1-2, 4</li> <li>• CC.COMP.PRVC.14- Managing Unauthorized Disclosures and Breach Notification Process</li> <li>• Notice of Privacy Practices is available upon request</li> <li>• LHCC Member Handbook – p. 77</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 II—Member Rights and Confidentiality		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Only reissue Notice of Privacy Practices if there are material changes</li> <li><a href="#">Link to Notice of Privacy Practices on LHCC website.</a></li> </ul>	
<p><b>MCE Description of Process:</b> The attached evidence demonstrates our compliance with the HIPAA Privacy Rule, which requires that individuals be provided with adequate notice of the uses and disclosures of their protected health information (PHI). Our Notice of Privacy Practices clearly outlines how LHCC may use and disclose PHI, the members’ rights regarding their information, and our legal duties to protect it. This notice is made available to all members via the member handbook and upon request. It is updated as necessary to reflect any material changes in our privacy 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	=	24	X	1	=	24
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	24	<b>Total Score</b>	=		24

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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**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>LHCC Member Handbook, p. 69</li> <li>Member services staff described that member profile is viewable during call. Those preferences can be updated by staff as well. Member services submits a workflow via internal operating system.</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Member Material Request</li> <li>Web Support A User - Medicaid</li> </ul>	Y <input checked="" type="checkbox"/> N <input 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>LHCC Member Handbook, p. 25, 32, 69</li> </ul> <b>Evidence in Virtual Review:</b> <ul style="list-style-type: none"> <li>All member service calls are recorded. Calls are audited by a quality assurance team (in accordance with soft skills. Audit 8 calls per staff member (minimum). There is a tool where the calls are housed, if remediation is identified, the supervisor receives a “package” to reflect needed training. Database documents all trainings that happen.</li> <li>Leadership randomly monitors calls and provides real-time feedback.</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>CC.MSPS.24 MP Call Audit and Quality Criteria and Protocol</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)(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>LHCC Member Handbook, p. 69</li> </ul> <b>Evidence in Virtual Review:</b> <ul style="list-style-type: none"> <li>(See grievance log). Grievances are categorized by member rights; if a member complains that rights were violated, this is noted in the tracking system and the grievance department contacts the team lead to initiate remediation.</li> <li>Care management processes for care planning.</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCC Member Handbook, p. 69</li> </ul> <b>Evidence in Virtual Review:</b> <ul style="list-style-type: none"> <li>Care management processes for care planning.</li> </ul> <b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Provider Manual</li> <li>BAA</li> <li>Provider website</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220	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"/>



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Standard II—Member Rights Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LHCC Member Handbook, p. 69</li> </ul> <p><b>Evidence in Virtual Review:</b></p> <ul style="list-style-type: none"> <li>• The MCE has provider representatives specific to hospital systems and have ongoing communications. If made aware of a member complaint, launch a quality of care investigation and if warranted, MCE will remediate with hospital or refer for peer review.</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Provider Manual</li> <li>• BAA</li> <li>• Provider website</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 checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.PRVC.10 - Individual_Rights_to_Protected_Health_Information, p. 3-4</li> <li>• LHCC Member Handbook, p. 60, 69, 83</li> </ul>	



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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>LA_Healthcare_Connections_Provider_Manual 12.2023, p. 19-21; 71</li> <li>LA_Healthcare_Connections_Provider_Manual 4.2024, p. 19-22</li> <li>LA_Healthcare_Connections_Provider_Manual 12.2024, p. 19-22</li> </ul>	Y <input checked="" type="checkbox"/> N <input 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>LHCC Member Handbook, pg. 29, 42</li> </ul> <b>Evidence in Virtual Review:</b> <ul style="list-style-type: none"> <li>Member service audits include calls types such as requests to change plans. MCE provides warm transfer to enrollment broker.</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	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>CC.COMP.42_Non-discrimination_in_Health_Program_Activities, Section - Policy p. 1</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
MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	



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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>Policy: LA.MRKT.10_Website_Guidelines_4.24 HSAG.docx</li> <li>LHCCMemberHandbook_HSAG_MKT.pdf</li> <li>Provider Directory front matter2024HSAG.pdf</li> <li>Proof of Website Accessibility:             <ul style="list-style-type: none"> <li>– 508 Compliance Evidence: LHCC Member Handbook ENG_Acrobat Accessibility Report.pdf/LHCC Member Handbook_SP_Acrobat Accessibility Report.PDF</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 III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>NET 5I 2024 (MY 2024) Website Usability Centene MCD - FINAL.docx (pg 10- Section IV: Key Findings)</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections provides all member materials in a format that are readily accessible by reviewing all digital materials are 508 compliant, most often using Adobe accessibility tools, and at a 6.9 or below reading level, most often using the Flesch-Kincaid tool integrated into MS Word. Additionally, we do website accessibility testing upon major updates and at least annually.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s “find a provider” landing page, when tested using the Web Accessibility Evaluation Tool (WAVE), generated a total of 23 errors, indicating the website may not be readily accessible.</p>		
<p><b>Required Actions:</b> The MCE must provide 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. The MCE must evaluate its website for accessibility and remediate any identified errors.</p>		
<p>2. The MCE uses the definitions for managed care terminology developed by the State including:</p> <p>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><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>Policy: LA.MRKT.12_Member_Handbook_HSAG.docx</li> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 86 - Section: Glossary)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Confirmed that the definition of "Appeal" in the glossary matches the definition in the Marketing</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 style="text-align: right;">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>	& Member Education Companion Guide issued by LDH.	
<b>MCE Description of Process:</b> Louisiana Healthcare Connections provides a glossary in the Member Handbook that describes the required terms.		
<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 MCE uses State-developed model member handbooks and member notices.</p> <p>PIHP:</p> <p style="padding-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;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policy: LA.MRKT.12_Member_Handbook_HSAG.docx</li> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (entire)</li> <li>• Notices: LA_Medicaid_LTS.zip               <ul style="list-style-type: none"> <li>– GRV_Adult Ack_General Use_LA</li> <li>– GRV_Adult Ack_General Use_LA_Spanish</li> <li>– Member Reimbursement_Denied_LA_rev05.22</li> </ul> </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
	<ul style="list-style-type: none"> <li>– SP_Member Reimbursement_Denied_LA_rev05.22</li> <li>– GRV_Adult Resolution_LA</li> <li>– GRV_Adult Resolution_LA_Spanish</li> </ul>	
<p><b>MCE Description of Process:</b> Member handbooks and notices are developed based on models/templates established by LDH, and all member materials receive LDH approval prior to use.</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>		
Language and Format		
<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><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> </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>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>	<ul style="list-style-type: none"> <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>• Policy: LA.MRKT.22_ Interpretation_ and_ Translation_ Services_ .docx</li> <li>• Provider Directory front matter2024HSAG.pdf (English and Spanish)</li> <li>• LHCCMemberHandbook_HSAG_MKT.pdf</li> <li>• (Taglines are on page 110 – Section: Translations are Available; additional info provided to members on pg 3- Section: Other Formats and Languages; 70- Section: Member Rights and Responsibilities; pg 47 Section: Translation and Interpreter Services)</li> <li>• LHCCMemberHandbook_Spanish.pdf (file)</li> <li>• Medicaid member comms web and email notice HSAG.pdf</li> <li>• LA NCQA Member Mailer English and Spanish.pdf (file)</li> <li>• LA_Medicaid_LTS.zip               <ul style="list-style-type: none"> <li>– GRV_Adult Ack_General Use_LA</li> <li>– GRV_Adult Ack_General Use_LA_Spanish</li> <li>– Member Reimbursement_Denied_LA_rev05.22</li> <li>– SP_Member Reimbursement_Denied_LA_rev05.22</li> </ul> </li> </ul>	



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>– GRV_Adult Resolution_LA</li> <li>– GRV_Adult Resolution_LA_Spanish</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• On page 2, the first paragraph includes "We will be happy to give you written translations, oral interpretation, sign language and other formats for any member materials, all for free."</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>• Definition of conspicuously visible font: We follow the MCO contract section 2.14.8.1’s font size guidance, which states “All written materials shall be clearly legible with a minimum font size of twelve (12)-point...”</li> <li>• Mechanisms to ensure taglines are included as part of all critical member materials: State-approved taglines that comply with all required elements are embedded in the design files for the Member Handbooks and Provider Directories. Appeal and grievance notices, and denial and termination notices are generated within the population health technology platform, and the state-approved taglines are programmed for inclusion on all such notices.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element. While the written document reviewed by HSAG indicated that written materials are available in “other formats” at no cost to the member, it did not reference auxiliary aids such as large print or braille.</p> <p><b>Recommendations:</b> HSAG recommends that LHCC revise its written material to include these examples.</p>		
<p><b>Required Actions:</b> No action required.</p>		
<p>5. The MCE makes interpretation services available to each member free of charge.</p> <p style="padding-left: 20px;">a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL).</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>	<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>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;">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>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policy: LA.MRKT.12_Member_Handbook_HSAG.docx (pg 2)</li> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 70 - Section: Member Rights and Responsibilities and pg 47 Section: Translation and Interpreter Services)</li> <li>Language Utilization reports and joint vendor oversight Q42024.pptx</li> </ul>	
<p><b>MCE Description of Process:</b> Any and all interpretation, translation, alternative format, etc. is provided free of charge to 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>6. The MCE notifies members:</p> <p>a. That oral interpretation is available for any language and written translation is available in prevalent languages;</p> <p>b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and</p> <p>c. How to access these services.</p> <p style="text-align: right;">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>Policy: LA.MRKT.12_Member_Handbook_HSAG.docx</li> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 70- Section: Member Rights and Responsibilities and pg 47 Section: Translation and Interpreter Services)</li> <li><a href="https://www.louisianahealthconnect.com/language-assistance.html">https://www.louisianahealthconnect.com/language-assistance.html</a></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>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>The phrase "auxiliary aids and services" was adapted to reduce reading level to below the 6.9 requirement and improve comprehension.</li> <li>This topic is addressed on page 106 of the Handbook: "Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats)."</li> <li>See uploaded: LHCCMemberHandbook_HSAG_MKT</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections outlines in our member handbook and online how members may request oral interpretations, auxiliary aids and services by contacting our Member Services line. Additionally, this notification is repeated in taglines across a wide range of other member education materials and via mail/email annually.</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 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</li> </ol>	<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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency.</p> <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>	<ul style="list-style-type: none"> <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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policy: LA.MRKT.09_Written_Materials_Guidelines_HSAG.docx</li> <li>Provider Directory front matter2024HSAG.pdf</li> <li>LA NCQA Member Mailer English and Spanish.pdf</li> <li>Language Utilization reports and joint vendor oversight Q42024.pptx</li> <li>JOC_Q2_2024_August_Translation_Station_FINAL.pdf</li> <li>LA_Medicaid_LTS.zip               <ul style="list-style-type: none"> <li>– GRV_Adult Ack_General Use_LA</li> <li>– GRV_Adult Ack_General Use_LA_Spanish</li> </ul> </li> </ul>	



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	<ul style="list-style-type: none"> <li>– Member Reimbursement_Denied_LA_rev05.22</li> <li>– SP_Member Reimbursement_Denied_LA_rev05.22</li> <li>– GRV_Adult Resolution_LA</li> <li>– GRV_Adult Resolution_LA_Spanish</li> </ul>	
<p><b>MCE Description of Process:</b> We do not send formal member newsletters, so none are submitted. All member materials are developed in compliance with this section and receive LDH review and approval prior to use.</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>		
Information for Members		
<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> <ol style="list-style-type: none"> <li>a. Thirty calendar days prior to the effective date of the termination; or</li> <li>b. Fifteen calendar days after receipt or issuance of the termination notice.</li> </ol> <p>PAHP:</p> <ol style="list-style-type: none"> <li>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.</li> </ol> <p style="text-align: right; margin-right: 20px;">42 CFR §438.10(f)(1) 42 CFR §457.1207</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</li> </ul>	<p><input type="checkbox"/> Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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MCO Contract: 2.13.9.2 PAHP Contract: 2.6.11.4 PIHP Contract: 5.14.1.2	evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members <ul style="list-style-type: none"> <li>Tracking or reporting mechanism that demonstrates timeliness</li> </ul>	
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Policy: LA.ELIG.25_Member Reassignment policy (Page 5 section “Identification and Notification”)</li> <li>Training Document Samples for Addressing Members Impacted by Terms</li> <li>Screenshots Termination Notification Tracking System</li> <li>Termination Notification System Export Report</li> <li>Examples MCE Provider Term Notifications</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC supports members’ continuity of care and notification in the event of provider terminations. This includes mailing notification letters to the member, reassigning the member to a new PCP, and re-issuing a new ID card based on that reassignment. See file LA.ELIG.25_Member Reassignment policy (Page 5 section “Identification and Notification”. Staff is trained to Identify impacted membership, and support reassignment / notification of that membership – see document named “Training Document Samples for Addressing Members Impacted by Terms” for an overview of basic identification reports and systems training.</p> <p>LHCC tracks the timeliness of responding to Provider Termination notification for Member outreach and reassignment via a digital tracking site – screenshots from this site are visible in file “Screenshots Termination Notification Tracking System.” Records and reports can be exported from this system as needed. See Sample export report for Case examples in file name – Termination Notification System Export Report.</p> <p>The sample cases exported from the Termination Notification System Export Report file were pulled out in greater detail in the document - <i>Examples MCE Provider Term Notifications</i>.</p> <p>Within the document - <u>Examples MCE Provider Term Notifications</u>:</p>		



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<p>The member examples Requested are broken out by Tab and contain details on Letter codes / provider types, date created (notified of term), effective date of termination, and date letters sent. Along with 3-member sample letters from each letter batch associated with the TERM.</p> <ul style="list-style-type: none"> <li>○ There are 2 Examples of Voluntary Future Term</li> <li>○ There are 2 Examples of Voluntary Past Term</li> <li>○ There are 2 Examples of Non-Voluntary Term</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. During the review period, LHCC confirmed two member notifications of provider terminations were not provided within the required time frame.</p>		
<p><b>Required Actions:</b> The MCE must provide 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> <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="text-align: right; margin-right: 50px;">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>• Policy: LA.MBRS.25_Member_Rights_and_Responsibilities_HSAG.docx</li> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (pg 70- Section: Member Rights and Responsibilities)</li> </ul>	<input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> Example of physician incentive plan provided to a member upon request: To date, this has not been requested. If it were requested, we would develop a reading-level compliant overview of the incentive plan(s) (which are compliant with section 2.17 of the MCO contract, <i>Value-Based Payment</i>) in which their provider(s) participate at that time. If the member requested information that was not</p>		



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specific to their provider(s), we would prepare the information pursuant to their request (for instance, if they wanted an overview of all types of incentive plans vs. just those their provider participates in).		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Member Handbook		
<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> <ol 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> </ol> <p>PAHP:</p> <ol style="list-style-type: none"> <li>a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member</li> </ol>	<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>• Policy: LA.MRKT.12_Member_Handbook_HSAG.docx</li> <li>• LHCC_WelcomeBooklet_INT_2024-10--PRINT.pdf</li> <li>• LHCCMemberHandbook_HSAG_MKT.pdf</li> <li>• LA NCQA Member Mailer English and Spanish.pdf (file)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>file to each person who is newly enrolled or re-enrolled:</p> <p>i. A current enrollee handbook</p> <p style="text-align: right;">42 CFR §438.10(g)(1)            42 CFR §438.10(g)(3)            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> We comply with option C, providing members with a mailed welcome packet and annual mailers on how to access the digital Handbook or request a printed copy. This includes information about translations, alternate formats, and auxiliary services to facilitate access to the Handbook. We mail printed Member Handbooks upon 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>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></p> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook.pdf</li> <li>• <a href="https://www.louisianahealthconnect.com/members/medicaid/resources/handbooks-forms.html">https://www.louisianahealthconnect.com/members/medicaid/resources/handbooks-forms.html</a></li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook_HSAG_MKT.pdf</li> <li>• On page 92, Grievance or Appeal form, "HAVE QUESTIONS OR NEED HELP? Call us at 1-866-595-8133 (TTY: 711), Monday through Friday, 7 a.m. to 7 p.m."</li> <li>• Page 42: Advanced Directive examples: "Living will: Tells doctors what kind of medical care you want to receive (or not receive) if you are no longer able to communicate what you want."</li> <li>• Effective 1/1/25, the updated version of our Handbook [LHCCMemberHandbook (2025-01-01).pdf] includes the following section on behavioral health treatments and advance directives on page 42:  "Advance directive for mental health treatment: Tells doctors your wishes for mental health treatment if you are no longer able to make decisions or communicate what you want. This lets you decide ahead of time which mental health treatments you would want or not want, including medications, short-term stay at a treatment center, electroshock therapy and outpatient services. You can also choose a person to make decisions for you if you are no longer able to make decisions or communicate what you want. This form cannot limit the state's authority to take you into protective custody or to involuntarily admit or commit you to a treatment facility. You can find</li> </ul>	



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	<p>this form and instructions on the Louisiana Department of Health’s website, at <a href="http://LDH.la.gov/page/mental-health-services">LDH.la.gov/page/mental-health-services</a>."</p> <ul style="list-style-type: none"> <li>Page 42: Advanced Directives, "Once complete, ask your doctors/providers to put the form in your file."</li> <li>Page 73: Major life changes            “Certain major life changes may affect your eligibility with Louisiana Healthcare Connections. If you have a major life change, please call the Medicaid Customer Service toll-free hotline at 1-888-342-6207, visit a local Medicaid eligibility office, or go to the Louisiana Medicaid Self-Service Portal at <a href="http://MyMedicaid.la.gov">MyMedicaid.la.gov</a> within 10 days after the change happens.”</li> <li>Page 78: Notice of Privacy Practices, Page 83: Your Rights addresses limitations on sharing information with family members.</li> </ul>	
<p><b>MCE Description of Process:</b> We provide member handbooks in both print and online formats for members. Content includes the required Member Handbook checklist information as well as LDH approval.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s member handbook did not include language that stated the following:</p> <ul style="list-style-type: none"> <li>The availability of assistance in the filing process for grievances.</li> <li>A description of advance directives which include the member’s rights under State Law to accept or refuse behavioral health treatment.</li> <li>Information regarding specialized behavioral health services (SBHS), 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 language in the member handbook that states the following:</p>		



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<ul style="list-style-type: none"> <li>The availability of assistance in the filing process for grievances.</li> <li>A description of advance directives which include the member’s rights under State Law to accept or refuse behavioral health treatment.</li> <li>Information regarding SBHS, including age(s) of consent for behavioral health treatment as per 42 CFR Part 2.</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>	<ul style="list-style-type: none"> <li>HSAG Required Evidence:</li> <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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policy and process: LA.MRKT.05_Materials_Approval_Process_HSAG.docx</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> All updates to our member materials are reviewed and receive state approval before publishing. Members are issued updated resources, as applicable. No significant changes were made during the review period, so no tracking information available to submit.</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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<b>Provider Directory</b>		
<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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policy: LA.MRKT.14_Provider_Directory_for_Members_HSAG.docx</li> <li>LA Region1 Provider Data.xlsx</li> <li>Copies of Q1,Q2,Q3 2024 Provider Directories:               <ul style="list-style-type: none"> <li>– LA_H0LA-001</li> <li>– LA_H0LA-002</li> <li>– LA_H0LA-003</li> </ul> </li> <li><a href="https://www.louisianahealthconnect.com/find-a-doctor.html">https://www.louisianahealthconnect.com/find-a-doctor.html</a></li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>PDFs of the paper directory were submitted (LA_H0LA-001.pdf). We are happy to mail a</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<p>paper copy as well; please provide a mailing address if desired.</p> <ul style="list-style-type: none"> <li>Evidence of compliant word document titled, <i>Evidence of compliance with Standard III Member Information, Element 13</i> uploaded. This is a series of screenshots that show how to get to the modalities of Dual Diagnosis and Pregnancy and Postpartum on the FAP.</li> <li>Evidence of child serving list is demonstrated in the screenshot: child adolescent psychiatry directory screenshot.jpg</li> </ul>	
<p><b>MCE Description of Process:</b></p> <ul style="list-style-type: none"> <li>Provider directories are printed quarterly and are mailed to members at their request. Members are able to search and filter providers using the Find A Provider tools on our website.</li> <li>Provider Directory templates (both print and online) are configured for all information required in the Provider Directory checklist. However, not all fields of data are available for all providers and blank fields are not displayed (i.e., some providers do not offer service in non-English languages, or do not have specialized cultural capabilities). We are including an Excel file that shows the range of provider data that is included in the directory.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s paper provider directory did not include the following components:</p> <ul style="list-style-type: none"> <li>Website Uniform Resource Locator (URL).</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> </ul>		



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<p><b>Recommendations:</b> HSAG recommends that the MCE ensure its public, searchable provider directory is 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> The MCE must include the following components in the paper provider directory:</p> <ul style="list-style-type: none"> <li>• Website URL.</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> </ul>		
<p>14. Information included in the MCE’s paper provider directory is updated at least:</p> <p>a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or</p> <p>b. Quarterly, if the MCE has a mobile-enabled electronic provider directory.</p> <p>PAHP:</p> <p>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;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Policy: LA.MRKT.14_Provider_Directory_for_Members_HSAG.docx</li> <li>• <a href="https://www.louisianahealthconnect.com/find-a-doctor.html">https://www.louisianahealthconnect.com/find-a-doctor.html</a></li> <li>• LHCC Flow Display in Directory.pdf</li> <li>• Copies of Q1,Q2,Q3 2024 Provider Directories:               <ul style="list-style-type: none"> <li>– LA_H0LA-001</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>– LA_H0LA-002</li> <li>– LA_H0LA-003</li> </ul>	
<p><b>MCE Description of Process:</b> The paper Provider Directory is updated quarterly, and our online electronic provider directory is mobile-enabled. Ongoing validation is made to be sure provider information is accurate and the online provider directory updates are made within 30 days of receipt and verification of updated provider 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>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>a. The web-based online version shall be updated in real time, but no less than weekly.</p> <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><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 provider information and the date the change was reflected in the electronic provider directory</li> <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>• Policy: LA.MBRS.30 Provider_Directory_and_Electronic_Files_from_Portico_12.2024</li> <li>• Policy: LA.MRKT.14 Provider Directory for Members 12</li> <li>• Examples of update tracking:               <ul style="list-style-type: none"> <li>– LPDM 253- Cen Prov tickets screenshots</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>– LPDM 253- JIRA</li> <li>– LPDM 278 - Cen Prov tickets screenshots</li> <li>– LPDM 278 JIRA</li> <li>– LPDM 1335 Cen Prov tickets screenshots</li> <li>– LPDM 1335 JIRA</li> <li>– Secure Directory Updates for Cenla Children’s Clinic</li> <li>– CCSWLA age range</li> </ul>	
<p><b>MCE Description of Process:</b> Provider data updates are processed within 30 days, and changes are reflected in near-real-time in the electronic provider directory.</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’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;">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>• Policy: LA.MRKT.14_Provider_Directory_for_Members_HSAG.docx</li> <li>• <a href="https://www.louisianahealthconnect.com/find-a-doctor.html">https://www.louisianahealthconnect.com/find-a-doctor.html</a></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
	<ul style="list-style-type: none"> <li>Machine-readable provider directory data is publicly available via API:  <a href="https://partners.centene.com/applicationDeveloper">https://partners.centene.com/applicationDeveloper</a></li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Our online provider directory was developed to be natively machine readable by assistive software:  “Online Provider Directory screenshot.docx”</li> </ul>	
<p><b>MCE Description of Process:</b> Machine-readable provider directory data is publicly available via API.</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 verify compliance with the requirements of this element. LHCC staff reported that the online provider directory is “natively machine readable by assistive software.” However, this did not demonstrate compliance with the requirement that the provider directory is available on the website in a machine-readable file and format as specified by the Secretary.</p>		
<p><b>Required Actions:</b> The MCE must have a provider directory available on the MCE’s website in a machine-readable file and format as specified by the Secretary.</p>		
Formulary		
<p>17. The MCE makes available in electronic or paper form the following information about its formulary:</p> <p>a. Which medications are covered (both generic and name brand).</p> <p>b. What tier each medication is on.</p> <p style="text-align: right;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Policy: LA.PHAR.OP.10 Preferred Drug List_04.2024.docx</li> <li>LDH PDL 1.2.2024</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• LDH PDL 2.1.2024</li> <li>• LDH PDL 3.1.2024</li> <li>• LDH PDL 4.1.2024</li> <li>• LDH PDL 5.1.2024</li> <li>• LDH PDL 6.1.2024</li> <li>• LDH PDL 7.1.2024</li> <li>• LDH PDL 8.1.2024</li> <li>• LDH PDL 9.1.2024</li> <li>• LDH PDL 10.1.2024</li> <li>• LDH PDL 11.1.2024</li> <li>• LDH PDL 12.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.1.2.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.2.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.3.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.4.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.5.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.6.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.7.1.2024</li> <li>• LHCC Member Website screen shot Pharmacy Benefits.8.1.2024</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LHCC Member Website screen shot Pharmacy Benefits.9.3.2024</li> <li>LHCC Member Website screen shot Pharmacy Benefits.10.1.2024</li> <li>LHCC Member Website screen shot Pharmacy Benefits.11.1.2024</li> <li>LHCC Member Website screen shot Pharmacy Benefits.12.1.2024</li> <li>We follow the state single PDL, which is linked on our website:  <a href="https://www.louisianahealthconnect.com/providers/pharmacy.html">https://www.louisianahealthconnect.com/providers/pharmacy.html</a></li> </ul>	
<p><b>MCE Description of Process:</b> As required by Louisiana State Law, we use the <a href="#">Louisiana Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)</a>. It is available via a link on our website, and members are notified about it in a variety of materials (i.e., welcome packet, handbook).</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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Policy: LA. PHAR.OP.10 Preferred Drug List_04.2024.docx</li> <li><a href="http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf">http://ldh.la.gov/assets/HealthyLa/Pharmacy/PDL.pdf</a></li> </ul>	
<b>MCE Description of Process:</b> As required by Louisiana State Law, we use the <a href="#">Louisiana Medicaid Preferred Drug List (PDL)/Non-Preferred Drug List (NPDL)</a> . Machine-readable formulary data is publicly available via API: <a href="https://partners.centene.com/applicationDeveloper">https://partners.centene.com/applicationDeveloper</a> .		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Electronic Materials and Communications		
19. Member information required in 42 CFR §438.10 may not be provided electronically unless the MCE meets all of the following: <ol style="list-style-type: none"> <li>The format is readily accessible.</li> <li>The information is placed in a location on the MCE’s website that is prominent and readily accessible.</li> <li>The information is provided in an electronic form which can be electronically retained and printed.</li> <li>The information is consistent with the content and language requirements of 42 CFR §438.10.</li> <li>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.</li> </ol> <p style="text-align: right;">42 CFR §438.10(c)(6) 42 CFR §457.1207</p> <p>MCO Contract: 2.14.1.8</p>	<b>HSAG Required Evidence:</b> <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> <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>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Policy: LA.MRKT.09_Written_Materials_Guidelines_HSAG.docx</li> </ul>	



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Requirement	Supporting Documentation	Score
PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7	<ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 7- Section Louisiana Healthcare Connections Website)</li> <li><a href="https://www.louisianahealthconnect.com/members/medicaid.html">https://www.louisianahealthconnect.com/members/medicaid.html</a></li> <li>LA NCQA Member Mailer English and Spanish.pdf (file)</li> <li>Request and tracking mechanism:               <ul style="list-style-type: none"> <li>– Member Material Request (19a_e).docx</li> <li>– 2024 Q4 Material requests tracking list (19a_e).xlsx</li> </ul> </li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>While it is our policy to provide materials in paper form within 5 business days, the timeline is not currently stated on our website. To improve compliance, we will update the website accordingly.</li> <li>See uploaded: Member Information-Paper Format Evidence</li> </ul>	
<p><b>MCE Description of Process:</b> 42 CFR §438.10 covers four categories of information for enrollees to be provided by MCOs:</p> <ul style="list-style-type: none"> <li>§ 438.10 (f) General requirements:           <ul style="list-style-type: none"> <li>Notice of termination of providers an enrollee uses – these notices are sent via paper mail, not electronic format, so this section is not applicable.</li> <li>Information about physician incentive plans upon request: Upon request, this information would be provided in the member’s preferred format (electronic, paper, audio, etc.), so this section is not applicable.</li> </ul> </li> </ul>		



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Standard III—Member Information		
Requirement	Supporting Documentation	Score
<ul style="list-style-type: none"> <li>§ 438.10 (g) Enrollee handbook: As described in previous sections, we comply with the Requirements of this section.</li> <li>§ 438.10 (h) Provider directory: As described in previous sections, we comply with the Requirements of this section.</li> <li>§ 438.10 (i) Formulary: As described in previous sections, we comply with the Requirements of this section.</li> </ul>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. Although LHCC stated that it is its policy to provide materials in paper form within five business days, LHCC’s website did not reference the specific time frame.</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>		

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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**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.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (pgs 11-16 Section: Your Covered Benefits)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (pgs 11-16-Section: Your Covered Benefits)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (pg 43- Section: Transportation for Health Needs)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207	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"/>



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Standard III—Member Handbook Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>We have no moral or religious objections to any covered services, so this requirement does not apply.</li> </ul>	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207	<p>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.</p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>We have no moral or religious objections to any covered services, so this requirement does not apply.</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4		
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207	<p>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.</p> <p><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></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pgs 54-55- Section: Chronic Care Management and Additional Health Support)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10		
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207	<p>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.</p> <p><i>The PIHP must also include procedures for plan of care development.</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 34- Section: Making Appointments and Getting Care)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11		
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207	<p>8. The extent to which, and how, after-hours care is provided.</p>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Standard III—Member Handbook Checklist		
Reference	Required Components	
MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 33- Section: After-Hours Appointment with Your PCP)</li> </ul>	
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207	9. What constitutes an emergency medical condition and emergency services. <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 39- Section: Emergency Care)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1		
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207	10. The fact that prior authorization is not required for emergency services. <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 40-Section: Emergency Care)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2		
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207	11. The fact that the member has a right to use any hospital or other setting for emergency care. <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 40- Section: Emergency Care)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5		
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207	12. Any restrictions on the member’s freedom of choice among network providers. <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 34- Section: Making Appointments and Getting Care)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5		



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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>LHCCMemberHandbook_HSAG_MKT.pdf (pg 28- Section: Family Planning Services)</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>LHCCMemberHandbook_HSAG_MKT.pdf (pg 19- Section: Copayments)</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>LHCCMemberHandbook_HSAG_MKT.pdf (pgs 69-70- Section Member Rights and Responsibilities)</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/primary 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>LHCCMemberHandbook_HSAG_MKT.pdf (pgs 8- Section Secure Member Portal and 103- Form: Request to Change My Primary Care Provider (PCP))</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xi)(A) 42 CFR §457.1207  MCO Contract: 2.13.6.2.18.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.1	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>LHCCMemberHandbook_HSAG_MKT.pdf (pg 65-Section: Grievance and 91- Form: Grievance or Appeal)</li> </ul>	
42 CFR §438.10(g)(2)(xi)(B) 42 CFR §457.1207  MCO Contract: 2.13.6.2.18.3 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.2	18. The requirements and timeframes for filing a grievance or appeal.	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>LHCCMemberHandbook_HSAG_MKT.pdf (pgs 65- Section: Grievance and 91- Form: Grievance or Appeal)</li> </ul>	
42 CFR §438.10(g)(2)(xi)(C) 42 CFR §457.1207  MCO Contract: 2.13.6.2.18.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.3	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"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 65-Section: Grievance)</li> </ul>	
42 CFR §438.10(g)(2)(xi)(D) 42 CFR §457.1207  MCO Contract: 2.13.6.2.18.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.6.1	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 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>LHCCMemberHandbook_HSAG_MKT.pdf (pgs 62- Section: State Fair Hearing for Appeals, 95- Form: Request for State Fair Hearing)</li> </ul>	
42 CFR §438.10(g)(2)(xi)(E)  MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2	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"/>



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Reference	Required Components	
PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 61- Section: Continuing to Receive Services)</li> </ul>	
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 member handbook 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 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>LHCCMemberHandbook_HSAG_MKT.pdf (pg 41- Section: Advance Directives)</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 Member Handbook 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>LHCCMemberHandbook_HSAG_MKT.pdf (Taglines are on page 110 – Section: Translations are Available; pg 3- Section: Other Formats and Languages; 70- Section: Member Rights and Responsibilities; pg 47 Section: Translation and Interpreter Services)</li> </ul>	



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Standard III—Member Handbook Checklist		
Reference	Required Components	
42 CFR §438.10(g)(2)(xiv) 42 CFR §457.1207  MCO Contract: 2.13.6.2.22; 2.13.6.2.23 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.21	24. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 4 – Section: Important Contacts)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xv) 42 CFR §457.1207  MCO Contract: 2.13.6.2.33 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.9	25. Information on how to report suspected fraud or abuse.  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 5- Section: Other Important Phone Numbers and 68- Section: Reporting Waste, Abuse and Fraud)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 9- Section: Your Member ID Card)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.20 PAHP Contract: NA PIHP Contract: NA	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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 74 - Section: Renewing Your Coverage)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.21	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"/>



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Reference	Required Components	
PAHP Contract: NA PIHP Contract: NA	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 35 Sections: How to Change and Appointment and How to Cancel an Appointment)</li> </ul>	
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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 73- Section: Other Insurance/Workers' Compensation)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 73 - Section: Other Insurance)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 68- Sections: Reporting Waste, Abuse and Fraud)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
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>  <b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LHCCMemberHandbook_HSAG_MKT.pdf (pg 2: Section :Last Revied)</li> </ul>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	<p>33. <i>The MCOs must include Information regarding SBHS, including, but not limited to:</i></p> <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 health providers;</i></li> <li>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></li> <li>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></li> <li>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></li> </ol> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LHCCMemberHandbook_HSAG_MKT.pdf (pgs 22-25- Section: Mental Health and Substance Use)</li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	<p>34. <i>The PIHP must include CSoC eligibility requirements;</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• MCO Contract: NA</li> </ul>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207  MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	<p>35. <i>The PIHP must include Member’s Bill of Rights;</i></p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• MCO Contract: NA</li> </ul>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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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>MCO Contract: NA</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>MCO Contract: NA</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></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>MCO Contract: NA</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>MCO Contract: NA</li> </ul>	



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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>MCO Contract: NA</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>MCO Contract: NA</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>MCO Contract: NA</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>MCO Contract: NA</li> </ul>	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	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"/>



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Reference	Required Components	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>MCO Contract: NA</li> </ul>	
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"/>
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>MCO Contract: NA</li> </ul>	



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**Provider Directory Checklist**

Standard II—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.	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024 - Page 1, Procedure Section, Item 1, subitem a, bullets 4 and 6, and item 6, subitem a, bullet 2</li> <li>LA.MRKT.14 Provider Directory for Members 12/24 - Page 2, Policy Section, Item 2.13.8.7.2</li> </ul>	
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).	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024 – Page 1, Procedure Section, Item 1, subitem a, bullets 9</li> <li>LA.MRKT.14 Provider Directory for Members 12/24 - Page 2- Policy Section – Item 2.13.8.7.2</li> </ul>	
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).	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024 - Page 1, Procedure Section, Item 1, subitem a, bullet 9, subitem b, bullet 3, and Item 6, subitem a, bullet 2</li> <li>LA.MRKT.14 Provider Directory for Members 12/24 - Page 2, Policy Section, Item 2.13.8.7.2</li> </ul>	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
42 CFR §438.10(h)(1)(iv) 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	4. Website Uniform Resource Locator (URL), as appropriate.	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>LA.MRKT.14 Provider Directory for Members 12/24 - Page 2, Policy Section, Item 2.13.8.7.2</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.	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024, Page 1, Procedure Section, Item 1, subitem 1, bullet 3</li> <li>LA.MRKT.14 Provider Directory for Members 12/24 – Page 1, Policy Section, Item 2.13.8.7.1, and Page 2, Policy Section, Item 2.13.8.7.2</li> </ul>	
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.	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024, Page, Procedure Section, Item 1, subitem a, bullet 7 and Page 2, Procedure Section, Item 6, subitem a, bullet 3</li> <li>LA.MRKT.14 Provider Directory for Members 12/24, Page 2, Policy Section, Item 2.13.8.7.2</li> </ul>	
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2	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.	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>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024, Page 1 - Procedure Section, Item 1, subitem a, bullets 8 and 12</li> </ul>	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	<ul style="list-style-type: none"> <li>LA.MRKT.14 Provider Directory for Members 12/24, Page 2, Policy Section, Item 2.13.8.7.2</li> </ul>	
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	<p>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.</p> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.MBRS.30 Provider Directory and Electronic Files from Portico 12.2024, Page 1, Procedure Section, Item 1, subitem a, bullet 10</li> <li>LA.MRKT.14 Provider Directory for Members 12/24, Page 2, Policy Section, Items 2.13.8.7.1 and 2.13.8.7.2</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	<p>9. The MCE provider directory components are included for the following provider types:</p> <ol style="list-style-type: none"> <li>Physicians, including specialists;</li> <li>Hospitals;</li> <li>Pharmacies;</li> <li>Behavioral health providers;</li> </ol> <p>The MCO provider directory components are included for the following provider types <i>and shall be delineated by parish and zip code</i>:</p> <ol style="list-style-type: none"> <li><i>Hospital primary care physician (PCP) groups</i></li> <li><i>Clinic settings</i></li> <li><i>Home and community-based services</i></li> <li><i>Outpatient therapy</i></li> <li><i>Residential substance use</i></li> <li><i>Youth residential services</i></li> <li><i>Inpatient mental health and residential substance use services</i></li> <li><i>Federally qualified health centers (FQHCs)</i></li> <li><i>Rural health clinics (RHCs)</i></li> </ol>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard II—Provider Directory Checklist		
Reference	Required Components	
	<ul style="list-style-type: none"> <li>j. <i>Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.</i></li> <li>k. <i>Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.</i></li> <li>l. <i>Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.</i></li> </ul> <p>The PAHP provider directory components are included for the following provider types:</p> <ul 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> </ul>	
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.MRKT.14 Provider Directory for Members 12/24, Page 1, Policy Section, Item 2.13.8.7.1</li> </ul>	
<p>MCO Contract: NA            PAHP Contract: 2.9.2.1.2.1.1            PIHP Contract: NA</p>	<p>10. <i>The PAHP provider directory must include the following:</i></p> <ul 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> </ul>	<p>Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/></p>
	<p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• N/A</li> </ul>	



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Standard II—Provider Directory Checklist		
Reference	Required Components	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. <i>The PAHP Provider Directory must also include the following:</i> a. <i>Providers arranged by name in alphabetical order</i> b. <i>Showing the provider’s specialty,</i> c. <i>Providers listed by specialty in alphabetical order by name.</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>• N/A</li> </ul>	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. <i>The PIHP Provider Directory must include the following:</i> a. <i>Indication of populations served by the provider (e.g., age range of clients) and specialties;</i> b. <i>Identification of any restrictions on the member’s freedom of choice among providers;</i> 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> d. <i>Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.</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>• N/A</li> </ul>	



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**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="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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 1, Definitions</li> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - Pg. 18, Emergency Services</li> <li>2024 Provider Manual STD IV - Pg. 108, Emergency Care Services</li> <li>2024 LA Member handbook STD IV - Pg. 86, Glossary, Pg. 39, Emergency Care</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 reviews our policies and procedures, member and provider materials (i.e., member handbook, provider manual, etc.) to ensure it aligns with the definition of an 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> <ul style="list-style-type: none"> <li>Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.</li> <li>Serious impairment to bodily functions.</li> <li>Serious dysfunction of any bodily organ or part</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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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 1, Definitions</li> <li>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - Pg. 18, Emergency Services</li> <li>• 2024 Provider Manual STD IV - Pg. 108, Emergency Care Services</li> <li>• 2024 LA Member handbook STD IV - Pg. 86, Glossary</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 policies and procedures in place to ensure emergency services are rendered by a qualified provider (regardless if provider is in or out of network). Emergency and post stabilization services do not require prior authorization. The MCE ensures that members have access to emergency services twenty-four hours a day, seven days a week, to evaluate or stabilize an emergent medical condition.</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 defines “post stabilization 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>	<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>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>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 1, Definitions</li> <li>2024 Provider Manual STD IV - Pg. 108, Emergency Care Services</li> <li>2024 LA Member handbook STD IV - Pg. 40, Post-Stabilization Services</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE reviews our policies and procedures, member and provider materials (i.e., member handbook, provider manual, etc.) to ensure it aligns with the definition for “post stabilization 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 circumstances described in 42 CFR §438.114(e), to improve or resolve the member’s condition.</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 §438.114(c)(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> <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><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> <ul style="list-style-type: none"> <li>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 1, Policy</li> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - Pg. 14, Out-of-Network Services and pg. 18, Emergency Services</li> <li>2024 Provider Manual STD IV- Pg. 108, Emergency Care Services</li> <li>2024 LA Member handbook STD IV - Pg. 40, Out of Network Emergency Services</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> <li>LA Medicaid EQRO Audit - Emergency Services Claim Examples</li> <li>ARQ_ER Claims Configuration</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has policies and procedures in place to ensure that there is coverage and payment for Emergency Services, when services are rendered by a qualified provider (regardless if provider is in or out of network). Emergency services do not require prior authorization. The ARQ_ER Claims Configuration shows that claims payments configurations where no authorization is required in location 23 for all providers.</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 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</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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>specified in the definition of “emergency medical condition.”</p> <p>b. A representative of the MCE instructs the member to seek emergency services.</p> <p style="text-align: right;">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>	<ul style="list-style-type: none"> <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>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2, Coverage of Emergency Medical Services</li> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - Pg. 18, Emergency Services</li> <li>2024 Provider Manual STD IV- Pg. 108-109, Emergency Care Services</li> <li>2024 LA Member handbook STD IV - Pg. 86, Glossary</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> <li>LA Medicaid EQRO Audit - Emergency Services Claim Examples</li> <li>ARQ_ER Claims Configuration</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has policies and procedures in place that ensure that payment for members seeking emergency treatment and post-stabilization services is not denied including the following:</p> <ol style="list-style-type: none"> <li>1. 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.”</li> <li>2. A representative of the MCE instructs the member to seek emergency services</li> </ol>		



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Requirement	Supporting Documentation	Score
LHCC is unable to provide a claim payment algorithm for emergency services as our system is configured in config-auth ARQ which is priced to pay 100% at location 23; as shown in document ARQ_ER Claims Configuration.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Additional Rules for Emergency Services		
<p>6. The MCE does not:</p> <p>a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.</p> <p>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;">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>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2, Coverage of Emergency Medical Services</li> <li>2024 LA Member handbook STD IV - Pg. 12, Benefits Description</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> <li>LA Medicaid EQRO Audit - Emergency Services Claim Examples</li> <li>ARQ_ER Claims Configuration</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><b>MCE Description of Process:</b> The MCE has policies and procedures in place to ensure no member is denied services in the time of an emergency. We do not deny payment to the provider of Emergency Services for any evaluation. There is no prior authorization needed for emergency services based upon a list of diagnoses or symptoms, diagnostic testing, or treatment provided to a member for an emergency condition. The MCE will not refuse to cover an Emergency Service or procedure related emergency service based on the emergency room provider, hospital, or fiscal agent’s failure to notify the Member’s PCP, Contractor’s representative, or LDH of the Member’s screening and treatment within said timeframes. LHCC is unable to provide a claim payment algorithm for emergency and post stabilization services as our system is configured in config-auth ARQ which is priced to pay 100% at location 23, as shown in document ARQ_ER Claims Configuration.</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>• LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2, Coverage of Emergency Medical Services</li> <li>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - Pg. 18, Emergency Services</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 IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• 2024 Provider Manual STD IV - Pg. 108, Emergency Care Services</li> <li>• LA Medicaid HP Website Pre-Auth Tool</li> <li>• LA Medicaid EQRO Audit - Emergency Services Claim Examples</li> <li>• ARQ_ER Claims Configuration.</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has policies and procedures in place to ensure members are not held liable for payments in relation to receiving emergency medical treatment. Within the plan, emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and will be covered until the member is stabilized. The member who has an emergency medical condition or demonstration related emergency service shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. We will cover any screening examination services conducted to determine whether an emergent medical condition exists. These services are configured in our claims system and priced to pay 100% at location 23, which does not require prior authorization, as shown in document ARQ_ER Claims Configuration.</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) 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>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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2, Coverage of Emergency Medical Services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>2024 Provider Manual STD IV - Pg. 91, Prior Authorization and Notifications</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has policies and procedures in place to ensure members are transferred or discharged when members are sufficiently stable. The attending emergency room physician, or the treating provider, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. The plan provides coverage for emergency services according with such determination. The plan is financially responsible for post stabilization services obtained from any provider, regardless of whether they are within or outside the plan’s network. LHCC is unable to provide case examples in reference to peer-to-peer discussions as we do not require authorization for emergency or post stabilization 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>		
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 post stabilization 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>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2, Post-Stabilization Services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024 - Pg. 6, Out-of- Network Services</li> <li>2024 Provider Manual STD IV - Pg. 91, Prior Authorization and Notifications</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> </ul>	
<p><b>MCE Description of Process:</b> MCE has policies and procedures in place to ensure we are 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 and do not require prior authorization. LHCC does not have case examples for post stabilization services which are services that are rendered in the emergency room prior to the admission and are not billed separately from the emergency services claim.</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 post stabilization 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 MCE for pre-approval of further post stabilization 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>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> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 3, Post-Stabilization Services</li> <li>2024 Provider Manual STD IV - Pg. 91, Prior Authorization and Notifications, Pg. 108, Emergency Care Services</li> <li>LA Medicaid HP Website Pre-Auth Tool</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 policies and procedures in place to ensure we are 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 and do not require prior</p>		



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Requirement	Supporting Documentation	Score
<p>authorization. If the member is admitted following emergency room care and stabilization, the MCE still does not require prior authorization for the care. After the admission to an inpatient setting, the hospital is required to notify the Plan by the next business day of the admission. LHCC does not have a claims review workflow process for post stabilization services which are services that are rendered in the emergency room prior to the admission and are not billed separately from the emergency services claim.</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 post stabilization 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>a. The MCE does not respond to a request for pre-approval within one hour.</li> <li>b. The MCE cannot be contacted.</li> <li>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.</li> </ol> <p style="text-align: right; margin-right: 50px;">           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>	<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>• Process to track requests for pre-approval of post stabilization care services and timeliness of the MCE’s response</li> <li>• One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to post stabilization care services</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 2,3, Post-Stabilization Services</li> <li>• 2024 Provider Manual STD IV - Pg. 91, Prior Authorization and Notifications</li> <li>• LA Medicaid HP Website Pre-Auth Tool</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> The MCE has policies and procedures in place to ensure we are 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 and do not require prior authorization. If the member is admitted following emergency room care and stabilization, the MCE does not require a prior authorization for the care. After the admission to an inpatient setting, the hospital is required to notify the Plan by the next business day of the admission. The MCE will continue to remain financially responsible if we cannot be contacted or if 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. Post stabilization services are services that are rendered in the emergency room prior to admission and are not billed separately from the emergency services claim. MCE doesn’t have a case example due to no authorization being required for post stabilization 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>		
<p>12. The MCE limits charges to members for post stabilization 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, post stabilization care services begin upon inpatient admission.</p> <p style="text-align: right;">42 CFR §422.113(e)(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 post stabilization services</li> <li>• Three case examples of a provider submitted claim for post stabilization 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>• CC.UM.54_Emergency_and_Post_Stabilization_Services- Pg. 3, Post-Stabilization Services</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>2024 LA Member handbook STD IV - Pg. 57, Note</li> <li>LA Medicaid HP Website Pre-Auth Tool</li> <li>ARQ_ER Claims Configuration</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE has policies and procedures in place to ensure members are not liable for payment for post-stabilization care when services are rendered by a qualified provider (regardless of if provider is in or out of network) and do not require a prior authorization. LHCC is unable to provide case examples of an emergency provider claim as our system is configured in config-auth ARQ which is priced to pay 100% at location 23. The ARQ_ER Claims Configuration shows that claims payments configurations where no authorization is required in location 23 for all providers.</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>		
End of the MCE’s Financial Responsibility		
<p>13. The MCE’s financial responsibility for post stabilization 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> <li>An MCE representative and the treating physician reach an agreement concerning the member’s care.</li> <li>The member is discharged.</li> </ol> <p style="text-align: right;">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>	<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>LA.UM.12_Emergency_and_Post-Stabilization_Services_11.14.2024 - Pg. 3, Post-Stabilization Services</li> <li>2024 Provider Manual STD IV - Pg. 73, 15th bullet and sub-bullet</li> <li>2024 LA Member handbook STD IV - Pg. 40, Post Stabilization Service</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IV—Emergency and Poststabilization Services		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE has policies and procedures to ensure that the financial responsibility for post-stabilization care services and demonstration related post stabilization services approval will end that include the following:</p> <ul 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> <li>An MCE representative and the treating physician reach an agreement concerning the member’s care.</li> </ul> <p>The member is discharged.</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	=	13	X	1	=	13
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	13	<b>Total Score</b>		=	13

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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**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>HEA 5B 2025 (MY 2024) LA MCD CLAS Program Evaluation – Page 11, Table 1: Top 10 languages reported by membership 2024</li> <li>HEA 5B 2025 (MY 2024) LA MCD CLAS Program Evaluation – Page 12, Table 2: Top 10 languages requested interpreter services</li> <li>HEA 5B 2025 (MY 2024) LA MCD CLAS Program Evaluation – Page 16, Table 1: Member Reported Language to Practitioner Language Composition Comparison by Practitioner Type</li> <li>HEA 5B 2025 (MY 2024) LA MCD CLAS Program Evaluation – Page 17, Table 2: Member to Practitioner Race and Ethnicity Comparison</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 V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• LA.Cont.02-Network Selection and Retention – Page 2, Section 4</li> <li>• LHCC Provider Manual – Page 15, Section “Translation and Interpretation”</li> <li>• Ancillary Executed Agreement</li> <li>• Individual Executed Agreement</li> <li>• Hospital Executed Agreement</li> <li>• Organizational Executed Agreement</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Specialized Behavioral Health Network Provider Development Mangement Plan 2025 – Pages 19-26</li> <li>• 0220_Network_Adequacy_GEO_Access_Review SA2 2024</li> <li>• Although not required in the Network Development Management Plan report template, Physical Health is also monitored. See PH Utilization Dx CY 2024</li> <li>• Network Development Management Plan Report Template</li> <li>• Ancillary Executed Agreement</li> <li>• Individual Executed Agreement</li> <li>• Hospital Executed Agreement</li> <li>• Organizational Executed Agreement</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> LHCC maintains and monitors a network of appropriate providers that is supported by written network provider agreements and that is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical, cognitive, or behavioral health disabilities (LA.Cont.02-Network Selection and Retention, page 2). All providers are required to provide medical services to Limited English Proficiency members in a language he or she understands (LHCC Provider Manual, page 15). The health plan develops, embeds, and implements a quality management strategy and a Culturally and Linguistically Appropriate Services (CLAS) Program that is embedded within every staff role and department function. The health plan approaches quality assurance, quality management, and quality improvement as a culture, integral to all day to day operations to provide services that are accessible and responsive to all members-this accounts for diverse cultural and ethnic backgrounds, varied health beliefs and practices, limited English proficiency (LEP), disabilities, and differential abilities, regardless of race, color, national origin, sex, sexual orientation, gender identity, preferred language, or degree of health literacy.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s executed agreements demonstrated its written agreements with providers. LHCC’s Culturally and Linguistically Appropriate Services in Health and Health Care Plan, Network Selection and Retention policy, and provider manual outlined LHCC’s commitment to monitoring its network adequacy. However, LHCC did not analyze the provider network’s capabilities to serve members with special health care needs, such as physical or mental disabilities. LHCC subsequently submitted a Specialized Behavioral Health Network Provider Development Management Plan that stated that “LHCC analyzes behavioral health services based on information obtained from claims data. The information is stratified based on volume focusing on the top diagnosis codes including age (adult vs adolescent), sex, region, etc. The information is used to monitor utilization trends to anticipate potential network expansion needs.” While LHCC’s subsequent submission analyzed its provider network’s capabilities to serve members with mental disabilities, LHCC’s Specialized Behavioral Health Network Provider Development Management Plan did not analyze the provider network’s capabilities to serve 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</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><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>member’s designated source of primary care if that source is not a women’s health specialist.</p> <p style="text-align: right;">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>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.Cont.01-Network Adequacy policy - Page 9 “Direct Access to Women’s Health”</li> <li>LHCC Member Handbook – Page 28, Section 1, “Family Planning Services” and Page 35, Section 1</li> <li>LA.Cont.02-Network Selection and Retention – Page 1, “Provider Selection,” Section 1c.</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01.02_Women’s_Health_and_Family_Planning_Services_07.09.2024 (4)</li> <li>LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024</li> </ul>	
<p><b>MCE Description of Process:</b> The Contracting and Network Development and Provider Engagement Network Specialists Departments select and recruit providers by regularly monitoring and considering the numbers and types of providers required to ensure female members have direct access to an in-network women’s health specialist to provide routine and preventive health services (LA.Cont.02-Network Selection and Retention, page 1). As stated in the Network Adequacy policy, female members have direct access to an OB/GYN within LHCC’s network for routine OB/GYN services regardless of whether their PCP provides women’s health services. For coverage/authorization guidelines, LHCC may require women’s health specialists to submit claims or reports in specified formats before reimbursing services. Enrollees are encouraged by LHCC to receive family planning services through LHCC’s network to ensure continuity and coordination of care. An out-of-network provider shall be reimbursed no less than the Fee for Service rate in effect on the date of service. If the enrollee elects to receive family planning services outside of LHCC’s network, no additional reimbursements will be made to LHCC (LA.Cont.01-Network Adequacy Policy, page 9). Members do not need a referral from a doctor to choose a family planning provider (LHCC Member Handbook, page 28 &amp; 35).</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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.Cont.01-Network Adequacy policy – Page 5 “Access and Timeliness Standards”</li> <li>• LA.Cont.01-Network Adequacy policy – Page 9, “Direct Access to Women’s Health”</li> <li>• LHCC Provider Manual – Page 69, “Appointment Availability” and “Specialty Care Appointment Standards” &amp; Page 111, “Preventive Medicine for Women”</li> <li>• LHCC Member handbook – Page 28, Section 1, “Family Planning Services”</li> <li>• Complaint Analysis Example LDH Report 010</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Narrative</li> <li>• Report 010 LHC 2024 03</li> <li>• Report 010 LHC 2024 12</li> <li>• CAHPS- Adult</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
	<ul style="list-style-type: none"> <li>• CAHPS- Child</li> <li>• MCO Provider Network Companion Guide</li> <li>• Attachment F- Provider Network Standards Updated</li> </ul>	
<p><b>MCE Description of Process:</b> Family planning services are provided by a primary care provider, obstetrician, gynecologist, nurse practitioner, or certified nurse midwife (LHCC Member handbook, page 28). LHCC’s network includes sufficient family planning providers to ensure timely access to covered services and will make every effort to contract with all local family planning providers and will ensure reimbursement whether the provider is in or out of network (Network Adequacy Policy, page 9; LHCC Provider Manual, page 111). The timely access standard for family planning appointments is 1 week. For OB/GYN care for pregnant women in their 1<sup>st</sup> trimester, the standard is 14 days; the 2<sup>nd</sup> trimester is 7 days; and the 3<sup>rd</sup> trimester and a high-risk pregnancy in any trimester is 3 days (Network Adequacy Policy, page 5 and LHCC Provider Manual, page 69).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s Network Adequacy policy included the family planning access standard and stated that LHCC assessed its network adequacy at least annually and monitored against “quantifiable and measurable standards.” LHCC staff members also stated that the MCE “demonstrates its network includes sufficient family planning providers to ensure timely access to covered services.” LHCC’s provider manual included the family planning access standard, but the member handbook did not. LHCC submitted its 010 report but provided no network analysis related to family planning access. LHCC subsequently submitted a narrative and stated that “[b]eginning in Q1 2025, LHCC proactively added family planning to our secret shopper calls, aligning with other accreditation guidelines.” LHCC stated that it subsequently submitted two 010 reports, which, upon review, could not be located.</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;">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> <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
	<ul style="list-style-type: none"> <li>LA. Cont.01-Network Adequacy Policy – Pages 9-10 “Second Opinion”</li> <li>LHCC Provider Manual – Page 97, “Second Opinion”</li> <li>LA. Cont.02-Network Selection – Page 2 Section 7</li> <li>LHCC Member Handbook – Page 58, section 2 “Second Medical Opinion” and Page 69, “Member Rights and Responsibilities.”</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narrative</li> <li>LA.UM.01.01. Covered Benefits and Services 11.13.2024</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC will provide for a second opinion from an in-network provider or arrange for the member to obtain one outside the network at no cost to the member (LA.Cont.02-Network Selection and Retention, page 2). The member can request a second opinion when there is a question over diagnosis or options for surgery or other treatment of a health condition, or when requested by any member of the member’s health care team, including the member, parent and/or guardian, or a social worker exercising a custodial responsibility. Authorization for a second opinion will be granted to an in-network or out-of-network provider if there is no in-network provider available. The second opinion will be provided at no cost to the member (LA.Cont.01-Network Adequacy Policy, pages 9-10, LHCC Member handbook, page 58 &amp; 69). Second opinions are not placed in a tracking format. Both in-network and out-of-network providers require prior authorization by LHCC for a second opinion (LHCC Provider Manual, page 97). After the second opinion is complete, the member’s provider will review and decide on the best treatment plan (LHCC Member Handbook, page 58).</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 required action.</p>		



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Requirement	Supporting Documentation	Score
<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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA. Cont.01-Network Adequacy Policy – Page 10 Section 2, “Out-Of-Network Services” and Section 3, “Out-Of-Network Protocols.”</li> <li>• LHCC Member Handbook – Page 40 Section 4, “Out-of-Network Emergency Services.”</li> <li>• 0220_Network_Adequacy_GEO_Access_Review SA2 2024</li> <li>• 348 LHCC 2024 Q4_348 GeoAccess Mapping</li> <li>• SCA – Final Executed Example 1</li> <li>• SCA – Final Executed Example 2</li> <li>• SCA – Final Executed Example 3</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Standard V – Network Adequacy Monitoring Mechanism (Sharepoint Screenshot for SCA Tracking)</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> If the member requires services that are not available from an in-network provider, the decision to authorize use of an out-of-network provider will be based on continuity of care, availability, and location of an in-network provider of the same specialty and expertise, and complexity of the case. LHCC will adequately and timely cover these services out of network for the member, for as long as the</p>		



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<p>LHCC’s provider network is unable to provide the services. The out-of-network provider is to submit to LHCC clean claims for services within thirty days and in no event greater than 180 days of the DOC. LHCC will compensate the provider for covered services provided to the member that has been approved. The provider will be reimbursed within forty-five days of receipt of a clean claim that reflects all documentation necessary to process the claim (SCA -Final Executed Examples). LHCC’s protocol is to ensure the services will be adequately covered in a timely manner within the shortest travel time of the member’s residence (LA.Cont.01-Network Adequacy Policy, page 10). Emergency services, if out-of-network, do not need approval from LHCC. All other out-of-network services may need prior authorization (LHCC Member Handbook, page 40).</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 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>• LA. Cont.01-Network Adequacy Policy – Page 10 Section 2, “Out-Of-Network Services.”</li> <li>• LA.CLMS.02 Provider Reimbursement – Page 1, Section 3.</li> <li>• LHCC Member Handbook – 40, Section 4, “Out-of-Network Emergency Services.”</li> <li>• LHCC Provider Manual – Pages 148-149, “Billing a Member”</li> <li>• SCA – Final Executed Example 1</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>• SCA –Final Executed Example 2</li> <li>• SCA - Final Executed Example 3</li> </ul>	
<p><b>MCE Description of Process:</b> To ensure that the cost to the member is no greater than it would be from an in-network provider, LHCC coordinates with respect to authorization and payment issues (LA.Cont.01-Network Adequacy Policy, page 10). All services except for emergency may need prior approval from LHCC, when out-of-network (LHCC Member Handbook, page 40). LHCC makes payments to covered emergency and post-stabilization services that are given by out-of-network providers. The LHCC provider manual, found on LHCC’s website, states providers may not balance bill members for covered services with the exception of copayment collection, if applicable (pages 148-149).</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 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>	<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>• 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>• Appointment Access_Policy – Pages 1-5, Provider Appointment Accessibility Standards &amp; Evaluation, Section “Procedure”</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LHCC Provider Manual: Page 69, Appointment Availability Section</li> <li>LHCC_ProviderEducation_AA: Page 1-2</li> <li>New Provider Orientation: Page 44</li> <li>LA.Cont.01-Network Adequacy Policy – Page 5, Section “Access and Timeliness Standards”</li> <li>MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>MCO Network Companion Guide, Attachment F-Provider Network Standards Updated</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC evaluates and educates on access to primary care, behavioral health, and specialty services through multiple methods, including New Provider Orientations, Routine Provider Visits, and telephonic audits. Additionally, monthly complaint data captured in Reports 010 and 409 and submitted to LDH is reviewed to identify trends and potential barriers to care. The Member Services department also monitors telephone accessibility on a monthly basis to ensure timely support for members. The Quality Assessment &amp; Performance Improvement Committee (QAPIC), or a designated subcommittee, analyzes all collected data and recommends actions to address any identified deficiencies in member access to care or services. These findings and recommendations are formally reported to and reviewed by the QAPIC to guide ongoing improvement efforts.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’s Network Adequacy and Appointment Access policies provided the appointment time access standards and stated that the MCE “measures access primary care services, behavioral health services and specialty services at least annually,” and that the MCE “will analyze the data and make recommendations to address deficiencies in member access to practitioners or member services.” LHCC’s provider manual, new provider orientation, provider education materials, and Provider Network Companion Guide accurately stated the appointment time access standards. LHCC’s Appointment Times Checklist was also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified.</p>		



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<p><b>Required Actions:</b> The MCE 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>		
<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.            PAHP:            Network providers must offer office hours at least equal to those offered by commercial dental insurance plans.            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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Provider Visit Policy: Page 1-2</li> <li>• Provider Orientations Policy: Pages 1-2, Section “Procedure”</li> <li>• LHCC Provider Manual – Page 70</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Narrative</li> <li>• Report 010 LHC 2024 03</li> <li>• Report 010 LHC 2024 12</li> <li>• Report 409 LHC 2024 03</li> <li>• Report 409 LHC 2024 12</li> </ul>	<p><input type="checkbox"/> Met  <input checked="" type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> LHCC provides education to providers on the LHCC Provider Manual, including access and timeliness standards, during both routine site visits and New Provider Orientations.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC staff stated that it subsequently submitted 010 and 409 reports, which, upon review, could not be located. LHCC 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>		



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<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 by commercial dental insurance plans.</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: 50px;">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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LHCC Provider Manual – Page 61, “24-Hour Access”</li> <li>LHCC Provider Manual – Page 69, “Appointment Availability”</li> <li>LHCC_ProviderEducation_AA: Page 1-2</li> <li>Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>AfterHours_ExampleQ42024Summary Report: Audit Report</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Provider Appointment Accessibility Standards &amp; Evaluation</li> <li>Network Policy</li> <li>Report 010 LHC 2024 03</li> <li>Report 010 LHC 2024 12</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>Report 409 LHC 2024 03</li> <li>Report 409 LHC 2024 12</li> <li>CAHPS- Adult</li> <li>CAHPS- Child</li> <li>LHCC NCQA Mystery Shopper Example 2024</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC provides ongoing education on appointment accessibility during routine provider visits and conducts a comprehensive annual assessment of access to care, including after-hours availability, through telephone outreach. In addition, monthly complaint data captured in Reports 010 and 409 and submitted to LDH is analyzed to identify trends and potential barriers to care. The Quality Assessment &amp; Performance Improvement Committee (QAPIC), or a designated subcommittee, reviews and evaluates this data to detect and address any deficiencies in member access to healthcare providers or member services. All findings and recommendations are reported to and reviewed by the QAPIC to support continuous improvement efforts.</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 establishes mechanisms to ensure compliance with timely access to care and services standards by network providers.</p> <p>a. The MCE monitors network providers regularly to determine compliance.</p> <p>b. The MCE takes corrective action if there is a failure to comply by a network provider.</p> <p style="text-align: right;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Appointment Access Policy – Pages 1-5, Provider Appointment Accessibility Standards &amp; Evaluation, Procedure Section</li> <li>Complaint Analysis Example LDH Report 010: Access to Care: Summary and Grievances Tab</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>• Complaint Analysis_BH_Example_0524: Summary and Grievances Tab</li> <li>• AA_AuditResults_BH_Q22024_359: Measure 1 and Measure 3 Tab</li> <li>• AfterHours_ExampleQ42024Summary Report: Audit Report</li> <li>• AA_Specialist_Example Q42024 Summary Report: Audit Report</li> <li>• CAHPS-A-Adult</li> <li>• CAHPS- A-CC</li> <li>• MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>• AAFailureEducationExample</li> <li>• AAFailureEducationExample_2</li> <li>• CorrectiveActionExampleLetter_SecondFailure</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Report 010 LHC 2024 03</li> <li>• Report 010 LHC 2024 12</li> <li>• Report 409 LHC 2024 03</li> <li>• Report 409 LHC 2024 12</li> <li>• CAHPS- Adult</li> <li>• CAHPS- Child</li> <li>• LHCC NCQA Mystery Shopper Example 2024</li> </ul>	



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<p><b>MCE Description of Process:</b> LHCC regularly monitors provider access and availability in alignment with the LDH Network Companion Guide, Attachment F, and NCQA standards. Monitoring activities include various mechanisms such as the CAHPS survey and complaint analysis, which are used to assess the majority of access standards. For specific areas such as behavioral health, specialty care, and after-hours access LHCC also utilizes mystery shopper audits.</p> <p>Practices identified as non-compliant due to voicemail-only systems with no returned calls to schedule appointments are contacted by their assigned Provider Network Specialist to confirm whether they are accepting new members. Additionally, practices that fail to meet appointment scheduling standards are provided with targeted education on appointment availability requirements.</p> <p>These non-compliant practices are included in the next quarter’s survey sample. If a practice fails a second time, a formal letter is issued requesting a Corrective Action Plan (CAP). Continued non-compliance after a third audit results in the case being escalated to the Quality Improvement Committee for review and recommendations on further corrective actions.</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> <li>• Analysis of provider network cultural competence</li> </ul> <p><b>Evidence as Submitted by the MCE:</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>LA.QI.CLAS.29 Cultural Competency and Linguistic Assistance Policy Pgs. 1-7, Entire Document</li> <li>LHCC Provider Manual – Page 15 Section “Translation and Interpretation” and Pages 79-80 Section “Evaluating Cultural Competency”</li> <li>2024 CLAS Workplan Columns A-L, Rows 9-44 &amp; 59</li> <li>Examples of Provider Profiles via the Provider Directory Find-A-Provider (FAP). Pgs. 2-4 examples showing cultural capacity of site. Pgs. 5-13 showing linguistic capacity of site.</li> <li>HE 5A 2024 (MY 2024) LA MCD CLAS Program Description &amp; Workplan - Pages 5-6, Section 1 “Workplan” ; Pages 10-13, Section III; Pages 14-15 Section IV</li> <li>HEA 5B 2025 (MY2024) LA MCD CLAS Program Evaluation - Pages 11-21 Section B, C, &amp; Domain: Communication and Language Assistance Table</li> <li>LA.Cont.02-Network Selection and Retention – Pages 2-3 Section 8</li> </ul>	
<p><b>MCE Description of Process:</b> Recognizing that a strong relationship between the individual/caregiver, physician, and care team enhances care coordination and is the key to improving the health and care experience for our members, we evaluate our practitioner network annually against the cultural, ethnic, racial, and linguistic needs and/or preferences of our member population. To support this effort, demographic data is collected from practitioners and practice. Race, ethnicity, and language proficiency is obtained through the enrollment process. Self-reported, practitioner demographic information is published in the provider directory for member access preferences. Through data, we can expose and analyze deficiencies in our practitioner network and adjust the network as appropriate. The annual report describes our assessment, methodology, monitoring, results, and analysis for each data source, and actions initiated to improve the network adequacy. The health plan is</p>		



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committed to ensuring that its policies and infrastructure are attuned to the diverse needs of all members, thereby taking active steps to reduce known healthcare disparities that stem from cultural and linguistic issues.		
<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;">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>LHCC Provider Manual – Page 80 Section 1 &amp; 5, “Assisting Individuals with Disabilities” and Page 22 Section 3.</li> <li>LA.Cont.02-Provider Selection and Retention - Page 1 section E and page 2 section 7</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>LA.Cont.05-Network Development and Management Plan – Page 2, Section 14</li> <li>Louisiana Credentialing Form, Page 2, Section 1, Page 3, Section 1, Page 4, Section 1, and Page 5, Section 1</li> <li>Provider Directory Accessibility</li> <li>LA.MBRS.30-Provider Directory and Electronic Files from Portico – Page 1 Section 1</li> <li>HE Dashboard Analysis</li> <li>LHC Facility Site Visit Form, Page 1, Section 2</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Narrative</li> <li>LA Provider Accessibility Self-Reporting 2024</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC’s Network Development and Management Plan requires specialized behavioral health providers to provide availability of services and appointments with physical access for persons with disabilities (LA.Cont.05-Network Development and Management Plan, page 2). In provider selection, the geographic location of providers and members, considering distance, travel time, the means of transportation used by members, and whether the location provides physical access for members with disabilities is considered (LA.Cont.02-Provider Selection and Retention, page 1). The LHCC network providers must ensure physical access, reasonable accommodations, and accessible equipment for members with physical, cognitive, or behavioral disabilities (LA.Cont.02-Provider Selection and Retention, page 2). Office sites are to adhere to the Americans with Disabilities Act and are assessed for accessibility. LHCC encourages providers to be flexible with appointment schedules for members who need additional time for health literacy (LHCC Provider Manual, page 80). Site reviews are performed at provider offices to evaluate appearance, accessibility, record-keeping practices, and safety procedures (LHC Facility Site Visit Form, Page 1, and LHCC Provider Manual, page 22). When a provider is credentialed, part of the process is to fill the Louisiana Credentialing Form, which contains a section for location accessibility. Members can access the LHCC provider directory to search for facilities that align with their accessibility needs (Provider Directory). The HE Dashboard provides a visual summary of the Provider network relative to the number of providers available to provide services to members with physical or mental disabilities by specialty, location,</p>		



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and provider demographics. This data is updated in real-time with a second iteration in development. The dashboard is evaluated for fidelity and data accuracy monthly.		
<b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC did not provide evidence that it ensures, through monitoring and data analysis, that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.		
<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.		
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>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>i. Offers an appropriate range of preventive, primary care, specialty services, and long-term services and 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>PIHP</p> <p>a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access</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><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.Cont.01-Network Adequacy Policy – Page 3&amp;4, entire pages, Page 5 Section 1, Page 6 Section 12 &amp; Page 10, Section 5, “Timely Access Exceptions,” &amp; Section 7 “Gap Analysis and Intervention.”</li> <li>• 0220_Network_Adequacy_GEO_Access_Review SA2 2024</li> <li>• 348 LHCC 2024 Q4_348 GeoAccess Mapping</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>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>MCE Description of Process:</b> LHCC analyzes its network adequacy on a quarterly basis by running Geo Access Maps for preventive, primary care, specialty services, key ancillary services, and hospitals (LA.Cont.01-Network Adequacy Policy, page 10). LHCC submits Network Adequacy reports to LDH on a quarterly basis using templates created by LDH. The Network Adequacy reports and analyses provide the requested range of provider types in combination with our membership data to show availability of services as outline in Attachment F-Provider Network Standards (LA.Cont.01-Network Adequacy Policy, pages 3-5). LHCC ensures a sufficient number of providers to meet minimum ratio requirements and allow adequate access for members. LHCC maintains a provider network that is adequate and reasonable in number, in specialty type, and in geographic distribution to meet the medical needs of its members without excessive travel requirements (LA.Cont.01-Network Adequacy Policy, page 6). LHCC may request an exception on the basis of community standards and must be justified, documented, and submitted to LDH for approval in a format specified by LDH. If the exception is approved by LDH, the exception gets monitored and the findings are provided to LDH as part of the annual Network Provider Development Management Plan (LA.Cont.01-Network Adequacy Policy, page 10). There are no exceptions to be approved by the State.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC’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 Standard: Time/Distance Checklist and Member-to-Provider Ratio Checklist for specific areas of noncompliance.</p>		



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<b>Timing</b>		
<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 would affect the adequacy of capacity in services, including:               <ol 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> </ol> </li> </ol> <p style="text-align: right; margin-right: 20px;">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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.Cont.05-Network Development and Management Plan – Page 1, “Policy.”</li> <li>• LA.Cont.02-Network Selection and Retention, Page 9, Sections 62 &amp; 63.</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• 0220 LHCC 2024 SA1 ~ Reporting</li> <li>• 0220 LHCC 2024 SA2 ~ Reporting</li> <li>• 0348 LHCC 2024 Q1 ~ Reporting</li> <li>• 0348 LHCC 2024 Q2 ~ Reporting</li> <li>• 0348 LHCC 2024 Q3 ~ Reporting</li> <li>• 0348 LHCC 2024 Q4 ~ Reporting</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> The Contracting and Network Development Department maintains a Network Development Management plan by evaluating successful interventions and making any revisions, if needed. The plan is submitted to LDH annually as well as when significant changes occur and is monitored throughout the year (LA.Cont.05-Network Development Management Plan Policy, page 1). LHCC will notify LDH for unexpected changes that would impair the provider network. The notification includes information about how the provider network change will affect the delivery of covered services and LHCC’s plan for maintaining the quality of member care. LHCC also submits documentation any time there has been a significant change in operations that would affect adequate capacity and services, including changes in value added benefits and services, payments, or eligibility of a new population. When LHCC receives this knowledge, a request for approval of</p>		



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Standard V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
<p>the material change with a copy of a draft notification for affected members will be sent 60 calendar days ahead of the expected implementation of the change. The request will include a description of any short-term gaps identified because of the change and alternatives that will be used to fill them. If LDH does not respond to the request within 30 days, the notice is deemed approved (LA.Cont.02-Network Selection and Retention, page 9).</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>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</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>• LA.Cont.01-Network Adequacy Policy – Page 7, Section 2 &amp; 3 and Page 10 “Timely Access Exceptions”</li> <li>• LA.Cont.05-Network Development and Management Plan – Page 2, Section 15 “Request Exceptions”</li> <li>• Specialized Behavioral Health Network Provider Development Management Plan 2025</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 V—Adequate Capacity and Availability of Services		
Requirement	Supporting Documentation	Score
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	42 CFR §457.1230(b)	
<b>MCE Description of Process:</b> LHCC ensures provider services identified in the Contract and MCO Manual are available from Network Provider within the specified distance from the member’s home. If an exception is needed, it is at the discretion of LDH and is considered based on the prevailing community standard. The request for exception is to be submitted in writing to LDH for approval (LA.Cont.01-Network Adequacy Policy, page 7). The request must be in a format specified by LDH and include data on the local provider population available to the non-Medicaid population. If the request is approved by LDH, LHCC will monitor the member access to the provider type in question on an ongoing basis and provide findings to LDH in the annual Network Development Management Plan (LA.Cont.01-Network Adequacy Policy, page 10 & LA.Cont.5-Network Development and Management Plan, page 2).		
<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 V—Adequate Capacity and Availability of Services							
<b>Total</b>	Met	=	9	X	1	=	9
	Not Met	=	6	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	15	<b>Total Score</b>	=	9	

<b>Total Score ÷ Total Applicable</b>	=	<b>60%</b>
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**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>MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>CAHPS-A-Adult</li> <li>CAHPS- A-CC</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	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>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Appointment Times Checklist	
Reference	Required Components
PIHP Contract: None	<p>f. <i>Residential withdrawal management: 24 hours when medically necessary</i></p> <p>g. <i>Psychiatric Residential Treatment Facility (PRTF): 20 calendar days</i></p> <p><i>PAHP:</i></p> <p>a. <i>Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:</i></p> <p style="margin-left: 20px;">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></p> <p style="margin-left: 20px;">ii. <i>Primary dental care: within 30 days</i></p> <p style="margin-left: 20px;">iii. <i>Follow-up dental services: within 30 days after assessment</i></p> <p><i>PIHP:</i></p> <p>a. <i>Urgent non-emergency behavioral health care: 48 hours</i></p> <hr/> <p><b>Evidence as submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>• Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>• ComplaintAnalysis_BH_Example_0524: Summary and Grievances tab</li> <li>• CAHPS-A-Adult</li> <li>• CAHPS- A-CC</li> <li>• AA_Specialist_Example Q42024 Summary Report: Audit Report</li> <li>• AA_AuditResults_BH_Q22024_359: Measure 1 and Measure 3 Tab</li> </ul>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
<b>Hospital and Emergency Services 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 PIHP Contract: 6.3.1.2.2.1	3. <i>MCO:</i> a. <i>Emergency care: 24 hours, 7 days/week within one hour of request</i> b. <i>Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request</i> c. <i>After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes</i>  <i>PAHP:</i> 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>  <i>PIHP:</i> a. <i>Emergent care: 24 hours, 7 days/week within one hour of request</i> b. <i>Emergent, crisis or emergency services must be available at all times.</i> c. <i>Urgent care: 24 hours, 7 days/week within 48 hours of request</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>• MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>• Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>• CAHPS-A-Adult</li> <li>• CAHPS- A-CC</li> <li>• AfterHours_ExampleQ42024Summary Report: Audit Report</li> </ul>		
<b>Prenatal Care and Family Planning Access Standards</b>		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)	4. <i>MCO:</i> a. <i>OB/GYN care for pregnant women:</i> i. <i>1st trimester: 14 days</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Standard V—Access Standards: Appointment Times Checklist		
Reference	Required Components	
MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	ii. <i>2nd trimester: 7 days</i> iii. <i>3rd trimester: 3 days</i> iv. <i>High risk pregnancy, any trimester: 3 days</i> b. <i>Family planning appointments: 1 week</i>	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>CAHPS-A-Adult</li> <li>CAHPS- A-CC</li> </ul>	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a)	5. <i>MCO:</i> <i>PAHP:</i> <i>PIHP:</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>
MCO Contract: None PAHP Contract: None PIHP Contract: None	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>MCO_ProviderNetworkCompanionGuide: Provider Network – Appointment Availability Standards Section, Page 8</li> <li>Complaint Analysis_Example_LDH Report 010: Access to Care: Summary and Grievances Tab</li> <li>CAHPS-A-Adult</li> <li>CAHPS- A-CC</li> </ul>	



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**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>• LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</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>• Attachment F does not have a ratio for hospitals. It is by distance standards. We are contracted with 100% hospitals in the state.</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	4. <i>Laboratory</i> 5. <i>Radiology</i> 6. <i>Pharmacy</i> 7. <i>Hemodialysis Centers</i>	Y <input type="checkbox"/> N <input type="checkbox"/> NA <input checked="" type="checkbox"/>



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Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	Required Components	
MCO Contract: Attachment F PAHP Contract: None PIHP Contract: None	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>Attachment F does not have a ratio for laboratory, radiology, pharmacy or hemodialysis centers. It is by distance standards.</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>	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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</li> </ul>	
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>	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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 5</li> </ul>	



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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	22. <i>Adult Physician Extenders: 1:1,000</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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 5</li> </ul>	
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	23. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500</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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 5</li> </ul>	
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	24. <i>Pediatric Physician Extenders: 1: 1,000</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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 5</li> </ul>	



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**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	1. <i>Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>  2. <i>Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):</i> <i>a. Rural Parishes: 30 miles</i> <i>b. Urban Parishes: 10 miles</i>  3. <i>Primary Dental Services:</i> <i>a. Rural Parishes: 30 miles one-way</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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</li> <li>Dental Services were not provided under LHCC in 2024.</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	4. <i>Acute Inpatient Hospitals</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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</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>• LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</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"/>



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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>



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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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 3</li> <li>LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</li> <li>Dental Services were not provided under LHCC in 2024.</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 checked="" type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>



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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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</li> </ul>	
<b>Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)</b>		
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> a. <i>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>LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</li> </ul>	
<b>Substance Abuse and Alcohol Abuse Center - Outpatient</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	28. <i>ASAM Level 1:</i> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 15 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	29. <i>ASAM Level 2.1:</i> a. <i>Rural Parishes: 30 miles</i> b. <i>Urban Parishes: 15 miles</i>	
	30. <i>ASAM Level 2WM:</i> a. <i>Rural Parishes: 60 miles</i> b. <i>Urban Parishes: 60 miles</i>	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</li> </ul>	
<b>Substance Use Residential Treatment Facilities (adult)</b>		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2)	31. <i>ASAM Levels 3.1</i> a. <i>Rural Parishes: 30 miles</i>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
42 CFR §457.1218 Contract  MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	<ul style="list-style-type: none"> <li><i>b. Urban Parishes: 30 miles</i></li> <li>32. <i>ASAM Levels 3.3</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 30 miles</i></li> <li><i>b. Urban Parishes: 30 miles</i></li> </ul> </li> <li>33. <i>ASAM Levels 3.5</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 30 miles</i></li> <li><i>b. Urban Parishes: 30 miles</i></li> </ul> </li> <li>34. <i>ASAM Levels 3.2-Withdrawal Management</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 60 miles</i></li> <li><i>b. Urban Parishes: 60 miles</i></li> </ul> </li> <li>35. <i>ASAM Level 3.7</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 60 miles</i></li> <li><i>b. Urban Parishes: 60 miles</i></li> </ul> </li> <li>36. <i>ASAM Level 3.7-Withdrawal Management</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 60 miles</i></li> <li><i>b. Urban Parishes: 60 miles</i></li> </ul> </li> </ul>	
	<b>Evidence as submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</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	<ul style="list-style-type: none"> <li>37. <i>ASAM Level 3.1</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 60 miles</i></li> <li><i>b. Urban Parishes: 60 miles</i></li> </ul> </li> <li>38. <i>ASAM Level 3.2 Withdrawal Management</i> <ul style="list-style-type: none"> <li><i>a. Rural Parishes: 60 miles</i></li> <li><i>b. Urban Parishes: 60 miles</i></li> </ul> </li> <li>39. <i>ASAM Level 3.5</i></li> </ul>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> NA <input type="checkbox"/>



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Reference	Required Components	
PIHP Contract: None	<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>•</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 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>• LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</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>• LA.CONT.01_Network_Adequacy_5.14.24 – Page 4</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>	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>Not Applicable</li> </ul>	
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract  MCO Contract: NA PAHP Contract: NA PIHP Contract: 6.3.1.1.1.3	43. <i>For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):</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>Not Applicable</li> </ul>	



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**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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.16_Continuity_and_Coordination_of_Services_ ; page 1.</li> <li>LA.CM.01_Care_Management_Program_Description_08.13.24: page 1.</li> <li>LA.ELIG.25_Member_Reassignment_Policy_10-08-24: page 3.</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 VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• 2024 Member Handbook: page 51.</li> <li>• 2024 Member Handbook: page 10.</li> <li>• 2024 Provider Manual: pages 61 &amp; 62.</li> <li>• Member Dashboard_HSAG: page 1.</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE guarantees that every member has a continuous source of care tailored to their needs and a designated person or entity responsible for coordinating the member’s accessed services. The members receive information on how to reach their designated Care Management support team as supported by the above required evidence.</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> <ol style="list-style-type: none"> <li>Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays.</li> <li>With the services the member receives from any other MCO, PIHP, or PAHP.</li> <li>With the services the member receives in fee-for-service (FFS) Medicaid.</li> <li>With the services the member receives from community and social support providers.</li> </ol> <p>MCO:</p> <ol style="list-style-type: none"> <li><i>Coordinate care between network PCPs and specialists, including specialized behavioral health providers;</i></li> <li><i>Coordinate care for out-of-network services, including specialty care services;</i></li> </ol>	<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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.16_Continuity_and_Coordination_of_Services_; pages 1 and 2.</li> <li>• LA.CM.01_Care_Management_Program_Description_08.13.24: pages 20, 31, and 47.</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>c. <i>Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;</i></p> <p>d. <i>Coordinate with the court system and State child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed.</i></p> <p><b>PAHP:</b></p> <p>a. <i>Coordination with the enrollee’s MCO:</i></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</i></p>	<ul style="list-style-type: none"> <li>LA.CM.101_Transition_of_Care_Policy_7.04.24_HSAG: page 1.</li> <li>LHCC Foster Care Transition Work Process_Example2: page 1.</li> <li>Findhelp Resource Document_Referrals and Closing the Loop 9.1.2024: page 2.</li> </ul>	



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><i>members when a return to home placement is not possible.</i></p> <p style="text-align: right;">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>		
<p><b>MCE Description of Process:</b> The MCE facilitates coordination of care between network primary care providers (PCPs), specialists, and specialized behavioral health providers as outlined in LA.UM.16 Continuity and Coordination of Care policy and procedure.</p> <p>b. The MCE manages coordination of care for out-of- network services, including specialty care when necessary.</p> <p>c. The MCE ensures that the services it provides are coordinated with those the enrollee receives from other health care providers.</p> <p>d. The MCE collaborates with the court system and State child-serving agencies concerning youth involved with these entities to help ensure access to appropriate 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>		
<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>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</i></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>LA.UM.16_Continuity_and_Coordination_of_Ser vices_ pages 4 &amp; 5.</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>agencies and require complex coordination of benefits and services.</i></p> <p style="text-align: right;">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>MCE Description of Process:</b> The MCO has procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies to ensure continuity of care. These procedures specifically address enrollees with co-occurring medical and behavioral health conditions, including children with special health care needs, who may require services from multiple providers, facilities, and agencies, necessitating complex coordination of benefits and 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>		
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/PAHPs</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>	<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> <ul style="list-style-type: none"> <li>LA.UM.16_Continuity_and_Coordination_of_Services_ : page 5.</li> <li>039 Report_Example3</li> <li>Tobacco_Example1</li> <li>LHCC Foster Care Transition Work Process_Example2</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE shares the results of any member identification and assessment with the State, as well as with other MCOs, PIHPs, and PAHPs serving the member, to avoid duplication of these efforts in compliance with HIPAA standards as outlined in LA.UM.16 Continuity and Coordination of Care policy and procedure. <b>Note:</b> This contract requirement is outlined in our Continuity and Coordination of Service policy and procedure; therefore, it is not repeated in detail in the Care Management 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>		
<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.</p> <p style="text-align: right;">42 CFR §438.208(b)(5) 42 CFR §457.1230(c)</p> <p>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</li> <li>Provider materials, such as the provider manual and provider contract</li> <li>Results of medical record review (MRR) or other oversight mechanisms for monitoring provider health record practices</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.16_Continuity_and_Coordination_of_Services_ : page 2.</li> <li>2024 Provider Manual: page 58, 79, 124, and 125.</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>LA.QI.13_Medical_Record_Reviews_11.2024 HSAG: page 1.</li> <li>069 LHCC 2024 Q4_Utilization_Management_Medical_Review_report_Report HSAG Reference</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE ensures that every provider delivering services to members keeps and shares the member’s health records, as appropriate, in line with professional standards. <b>Note:</b> This contract requirement is outlined in our Continuity and Coordination of Service policy and procedure; therefore, it is not repeated in detail in the Care Management Program Description. In addition to the above, LA.QI.13 policy and procedure references mechanisms for monitoring provider health record practices.</p> <p>The attached 069 LHCC 2024 Q4 Utilization Management Medical Record Report evidence that includes Medical Record Review Results.</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 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;">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>LA.UM.16_Continuity_and_Coordination_of_Services_12.04.2024_HSAG: page 1.</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 guarantees that member privacy is safeguarded throughout the care coordination process, in compliance with applicable privacy regulations and by following HIPAA verification guidelines as stated in LA.UM.16 Continuity and Coordination of Services policy and procedure. <b>Note:</b> This contract requirement is outlined in our Continuity and Coordination of Service policy and procedure; therefore, it is not repeated in detail in the Care Management Program Description.</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 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>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>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;">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>LA.CM.01.04_New_Member_Welcome_Calls_4.9.24_HSAG: page 2.</li> <li>Standard VI-Coordination and Continuity of Care-Requirement 7-HNA</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Within 90 calendar days of a new member's enrollment effective date, the MCO attempts to complete a health needs assessment. If the initial contact attempt is unsuccessful, the MCO must make and document at least three (3) separate attempts, varying		



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<p>the time of day and day of the week, to reach and assess the member. <b>Note:</b> This contract requirement is outlined in our New Member Welcome Call policy and procedure; therefore, it is not repeated in detail in the Care Management Program Description</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 LHCC 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 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</i></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>• LA.CM.01_Care_Management_Program_Description_08.13.24: pages 25, 26 and 27.</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>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>	<ul style="list-style-type: none"> <li>Standard VI-Coordination and Continuity of Care-Requirement _CMA</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE establishes processes to conduct comprehensive assessments of Medicaid members identified by the State—as having special health care needs. These assessments are designed to identify any ongoing conditions that may require a course of treatment or regular care monitoring. The assessment process involves applicable providers or individuals who meet the service coordination requirements set by the State or MCO, as applicable and outlined in LA.CM.01 Care Management 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>		
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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CM.01_Care_Management_Program_Description_08.13.24: page 32</li> <li>LA.CM.01.02_Care_Plan_Development_and_Implementation_5.2024_HSAG: page 3.</li> <li>Standard</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE develops a treatment plan for members with special health care needs who are assessed as needing ongoing treatment or regular care monitoring as outlined in LA.CM.01 Care Management Program Description. <b>NOTE:</b> This contract does not include LTSS language.</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> <li>c. Approved by the MCE in a timely manner, if this approval is required by the MCE.</li> <li>d. In accordance with any applicable State quality assurance and utilization review standards.</li> </ul> <p style="text-align: right; margin-right: 20px;">           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>	<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> <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>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> The treatment completed per the outline below:</p> <ul style="list-style-type: none"> <li>a. Be created by someone who meets SHCN requirements, with active participation from the member and input from any providers involved in the member's care.</li> </ul>		



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Requirement	Supporting Documentation	Score
b. Be developed by an individual trained in person-centered planning, following the person-centered planning process and plan as outlined in 42 CFR §441.301(c)(1) and (2) c. Be approved promptly by the MCE, if such approval is required. d. Comply with all applicable state quality assurance and utilization review standards. <b>NOTE:</b> This contract does not include LTSS language.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
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).  <div 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)           </div> MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary	<b>HSAG Required Evidence:</b> <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> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.CM.01_Care_Management_Program_Description_08.13.24: pages 35 and 36.</li> <li>LA.CM.01.02_Care_Plan_Development_and_Implementation__5.2024_HSAG: page 3.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> The treatment plan is evaluated and updated based on a reassessment of functional needs—at least once every 12 months, whenever there are significant changes in the member's condition or circumstances, or upon the member’s request as outlined in LA.CM.01 Care Management Program Description.		
<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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Standard VI—Coordination and Continuity of Care		
Requirement	Supporting Documentation	Score
<b>Direct Access to Specialists</b>		
<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;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2024 Member Handbook: pages 36 and 37.</li> <li>LA.UM.16.01_Referrals_to_SHC_Services_2024.09_HSAG: page 1 and 2.</li> <li>2024 Provider Manual: page 66 and 68.</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> For members identified through an assessment as requiring a course of treatment or ongoing care monitoring due to special health care needs, the MCE has a system in place that enables members to directly access a specialist tailored to the member’s condition and specific needs as outlined in the LHCC Member Handbook. <b>Note:</b> This contract requirement is outlined in our Continuity and Coordination of Service policy and procedure; therefore, it is not repeated in detail in the Care Management 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>		



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Results for Standard VI—Coordination and Continuity of Care						
<b>Total</b>	Met	=	11	X	1	= 11
	Not Met	=	1	X	0	=
	Not Applicable	=	0			
<b>Total Applicable</b>		=	12	<b>Total Score</b>	=	11

<b>Total Score ÷ Total Applicable</b>	=	<b>92%</b>
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**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>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 9, Covered Services</li> <li>LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024 - pg. 1, Policy</li> <li>2024 Provider Manual - Pg. 73, 2nd bullet</li> <li>2024 Member Handbook - Pg. 70, 1st bullet</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>ALL.CFG.AmisysFeeSchedule</li> <li>ALL.CFG.DSTFeeSchedule</li> <li>ALL.CFG.FeeSchedulesWithDateSpan</li> <li>MCD.CIA.FeeSchedules</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 Prior Authorization and Pre-Certification process requires the provider or practitioner to make a formal request to the MCE prior to services being rendered. The prior authorization request is screened for member eligibility, benefit coverage, and</p>		



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Requirement	Supporting Documentation	Score
assessed for medical necessity and appropriateness of the health services proposed, including the place of service. Prior Authorization is required for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.		
<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 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;">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>• LA.UM.01 Utilization Management Program Description_2024.02 - pg. 9, Covered Services</li> <li>• LA.UM.01.01 Covered Benefits and Services_11.13.2024 - pg. 2, Policy</li> <li>• 2024 Provider Manual - Pg. 73, 3rd bullet</li> <li>• 2024 Member Handbook - Pg. 70, 2nd bullet</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> For services that the MCE has determined require prior authorization, only the minimally necessary information is obtained to certify the admission, procedure or treatment, length of stay, or frequency and/or duration of services is collected. The diagnosis is only utilized when pertinent to the medical necessity criteria.		
<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 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><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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<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 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>• Coverage guidelines/criteria</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 12, Prior Authorization</li> <li>• LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024 - pg. 5, Family Planning Services</li> <li>• 2024 Provider Manual - Pg. 73, 3rd bullet, 3b - Pg.111, -Preventive Medicine for Women</li> <li>• 2024 Member Handbook - Pg. 70, 1st bullet, 3b - Pg. 28, Family Planning Services</li> </ul>	
<p><b>MCE Description of Process:</b> Authorizations are provided when the requested service is medically necessary and provided in the most efficient and cost-effective manner without compromising quality of care. The local delivery healthcare system is assessed to determine the availability of services and the ability to meet the member’s specific health care needs on an individual basis. LTSS services are non-applicable as LHCC is not contracted to provide those 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>		



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Requirement	Supporting Documentation	Score
<p>4. The MCE specifies what constitutes “medically necessary services” in a manner that:</p> <p style="margin-left: 20px;">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 style="margin-left: 20px;">b. Addresses the extent to which the MCE is responsible for covering services that address:</p> <p style="margin-left: 40px;">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 style="margin-left: 40px;">ii. The ability for a member to achieve age-appropriate growth and development.</p> <p style="margin-left: 40px;">iii. The ability for a member to attain, maintain, or regain functional capacity.</p> <p style="text-align: right; margin-right: 20px;">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>	<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>LA.UM.01_Utilization_Management_Program_Description_2024.02 – pg 19</li> <li>LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024 - pg. 1, Policy; pg. 2, Procedure</li> <li>2024 Provider Manual - 4a, bi, ii, iii - Pg. 90 as well as pg. 92, Medical Necessity</li> <li>2024 Member Handbook - 4a, bi, ii, iii - Pg. 56, Authorization and Medical Need</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> Covered services are those medically necessary health care services provided to members as outlined in the MCE contract with the State of Louisiana. Medical necessity means that the covered services prescribed are based on generally accepted medical practices in light of conditions at the time of treatment. Each medical decision must be case specific regardless of available practice guidelines.</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>Authorization of Services</b>		
<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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 23, Delegation</li> <li>• LA.UM.01.01_Covered_Benefits_and_Services_11.13.2024 – pg.2, Procedure</li> <li>• Advance Medical Review (AMR) Agreement</li> <li>• BHM_MSA_Amendment_Agreement</li> <li>• Involve Vision_Agreement_Amendment 15</li> <li>• Magellan_Agreement</li> <li>• MRIOA CSA Amendment – effective 9.9.2021</li> <li>• UM Delegated Vendors</li> <li>• AMR 2024 TPRMO Annual Audit Results Summary Redacted</li> <li>• Centene Vision Services 2024 TPRMO Audit Results Summary_Redacted</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>BHM 2024 TPRMO Audit Results Summary Redacted</li> <li>Evolent_NIA_2024_TPRMO_Combined_Annual_Audit_Results_Summary_Redacted</li> <li>Magellan ABA 2024 TPRMO Audit Results Summary_Redacted</li> <li>Magellan ABA_MSA</li> <li>Magellan Healthcare ABA_SOW</li> <li>NIA_Agreement_Amendment 3AA</li> <li>NIA_Agreement_Amendment 3B</li> <li>NIA_Agreement_Amendment 3F</li> <li>NIA_Agreement_Amendment 3H</li> <li>NIA_Agreement_Amendment 3Y</li> <li>NIA_Agreement_Amendment 15E</li> <li>NIA_Agreement_Amendment 15I 2</li> <li>NIA_Agreement_Amendment 15J</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>CC.COMP.60_-TPRM_Program</li> <li>2024 Due Diligence Questionnaires</li> <li>2024 UM and Mbr Appeal File Review Tool</li> <li>Medicaid NIA JOC Meeting Minutes 4.9.2024</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE’s clinical reviewers utilize InterQual criteria, which are nationally recognized standards of care and include input from recognized medical experts. In addition, we utilize Louisiana state policies, evidence-based clinical policies, and preventive health guidelines when making clinical decisions. UM criteria and the policies for application are reviewed at least annually and updated as appropriate. All subcontractors must follow written policies and procedures for processing requests. All delegated UM vendors are appropriately contracted with a Delegated Services Agreement (DSA) in order to establish their roles and responsibilities. Prior to delegating</p>		



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<p>services and at least annually thereafter, our corporate Third-Party Risk Management Office conducts audits of national vendors, including file reviews, to ensure appropriate processes are followed. Additionally, the health plan hosts or participates quarterly Joint Operational Committee meetings with all delegated vendors where there is an opportunity to review performance information and ask questions.</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;">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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01 Utilization Management Program Description 2024.02- pg. 11, Inter-rater Reliability (IRR)</li> <li>LA.UM.32 Interrater Reliability Testing 10.08.2024- entire P&amp;P</li> <li>2024 UM Program Evaluation - pg. 26, Inter-rater Reliability (IRR)</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.UM.32 Interrater Reliability Testing 10.08.2024</li> <li>CC.UM.42 Quality Auditing 2024.05</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 reviews the consistency of our clinical reviewers annually through our Inter-Rater Reliability (IRR) assessment process. On an annual basis, our clinical staff are tested on clinical subsets to assess their decision making and consistency with the</p>		



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<p>guidelines. These assessments evaluate determinations with the same criteria and clinical information used when reviewing a case. All reviewers must obtain a score of 90%. Reviewers who do not meet this standard will receive remediation and additional training. All IRR activities are shared with the Population Health and Clinical Operations Committee (PHCOC) for tracking purposes.</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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 3, Authority; pg. 7, Utilization Management Process</li> <li>2024 Provider Manual - Pg. 95, under Peer Clinical Review Process</li> <li>OP4072829798_Element 7</li> <li>IP4234346166_Element 7</li> <li>IP4106337557_Element 7</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Flowchart of Peer-to-Peer Process</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> The MCE will consult with the requesting provider when there is a lack of necessary information to make the medical necessity determination. The MCE communicates with our providers via fax, phone and/or prior authorization portal to request</p>		



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<p>additional and/or missing information. We may also outreach the provider in some cases for a peer-to-peer consultation when appropriate. Three Case examples of peer-to-peer consults are provided, OP4072829798_Element 7, IP4234346166_Element 7, IP4106337557_Element 7.</p>		
<p><b>HSAG Findings:</b> HSAG has scored this element as not applicable since State requirements differ from federal requirements. While the contract allows for an “informal reconsideration” process in which a denial is overturned following a peer-to-peer discussion, CMS has articulated that 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 adverse benefit determination (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> LHCC is not contracted to provide LTSS services</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</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>



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<p>made by an individual who has appropriate expertise in addressing the member’s medical, behavioral health.</p> <p>MCO:</p> <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>	<ul style="list-style-type: none"> <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><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 10, Medical Necessity Review</li> <li>UM PH PA Job Descriptions</li> <li>UM PH CCR Job Descriptions</li> <li>UM BH Job Descriptions</li> <li>MDs Job Descriptions</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>SharePoint Tracking Log- Excel</li> <li>SharePoint Tracking Log- Screenshot</li> </ul>	<input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> All Adverse Benefit Determinations are made by a physician or other peer review consultant who has the appropriate clinical expertise in treating the member’s condition or disease. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review. A Level II review is conducted case-by-case by an appropriately licensed practitioner or other health care professional with specific training in specialty. For instance, a dental denial would be reviewed by a dental practitioner whereas a behavior health reduction in services request would be handled by a qualified BH practitioner, etc.</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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<b>Notice of Adverse Benefit Determination</b>		
<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>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>	<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> <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>• LA.UM.01_Utilization_Management_Program_Description_2024.02 – pg. 15, Timeliness of UM Decisions and pg. 16, Denial Notices</li> <li>• LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg. 4, Provider Notification</li> <li>• 2024 Provider Manual - Pg. 94, Authorization Determination Timeline along with Pg. 149, Notice of Appeal Decision</li> <li>• Provider Admin Denial LA</li> <li>• Provider Denial LA</li> <li>• Provider Partial Denial LA</li> <li>• Provider Retro Admin Denial LA</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> The MCE sends a written notice of Adverse Benefit Determination to the member, member's authorized representative, and the requesting provider of any denial, reduction, or termination of service within the specified timeframes for the service authorization request type.</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> <ol style="list-style-type: none"> <li>a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.</li> <li>b. The reduction, suspension, or termination of a previously authorized service.</li> <li>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.</li> <li>d. The failure to provide services in a timely manner, as defined by the State.</li> <li>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.</li> <li>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.</li> </ol>	<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>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</li> <li>• LA.UM.08_Appeal_of_UM_Decisions_11.15.23 - pg. 1, Definitions</li> <li>• 2024 Member Handbook – pg. 61</li> <li>• 2024 Provider Manual - 11a, b, f) Pg. 148, Appeals</li> <li>• 2024 Provider Manual - 11c) Pg. 124, Clean Claim Definition</li> <li>• 2024 Provider Manual - 11d) Pg. 94, Prior Authorizations timely manner (last paragraph)</li> </ul> <p><b>Additional Evidence:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.07_Adverse_Determination_(Denial)_Notices_05.15.2024 (identified in virtual 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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<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>MCE Description of Process:</b> The MCE uses the definition of Adverse Benefit Determination (ABD) to support its medical necessity decisions and denials, up to and including member/provider rights for reconsideration or appeals. We review all authorization requests and make attempts to collect all necessary information to render a decision. LHCC does not have any claim payment denials that would have an ABD sent based on the claim denial. If an authorization is required for the service and the authorization request was denied, the claim will adjudicate and deny the service for no authorization on file for the billed service. ABDs are not required in this situation. The ABD would have already been sent to the provider based on the service authorization denial.</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 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> <p>a. The ABD the MCE has made or intends to make.</p> <p>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</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 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>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</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>the member’s ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.</p> <p>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).</p> <p>d. The procedures for exercising the rights specified in 42 CFR §438.402(b).</p> <p>e. The circumstances under which an appeal process can be expedited and how to request it.</p> <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: right;">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>• LA.UM.07_Adverse_Determination_(Denial)_Notices_05.15.2024 - pg. 4, Written Notification for Medical Necessity Adverse Determination</li> <li>• 2024 Provider Manual - 12a, b,c,d, e,f) Pg.95, Notice of (Adverse Determination)</li> <li>• Member Denial_LA</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Denial Samples-Revised 90225</li> <li>• Readability Process</li> </ul>	



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<p><b>MCE Description of Process:</b> For all adverse benefit determinations or partial approvals, the nurse reviewer sends the review to the medical director for secondary review, and the final determination is rendered. The Adverse Benefit Determination (ABD) letter is generated utilizing the medical necessity rationale from the MD and sent to the provider and member or member’s representative via mail inclusive of appeal rights and State fair hearing requests.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.  <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 ABD include all requirements and indicate that the reading grade level has been verified.</p>		
<p><b>Required Actions:</b> No action required.</p>		
Timeframe for Decisions		
<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><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>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 15, Timeliness of UM Decisions</li> <li>• LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg.2-3</li> </ul>	



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	<ul style="list-style-type: none"> <li>2024 UM Program Evaluation - pg. 10-11, Timeliness of UM Decision Making</li> <li>2024 LA Medicaid UM Notices TAT</li> <li>0188_Service_Authorizations_2024 Q1 Submission Element 13,14,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q2 Submission Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q3 Submission Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q4 Submission Element 13,14,15,16,22</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE makes attempts to collect all necessary information to render a decision as expeditiously as the members condition requires for standard authorizations. Once a final decision has been made, notification of the decision is communicated within the Louisiana Dept of Health-established turnaround time (TAT) frame of receiving the request for 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>		
<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 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)</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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p style="text-align: right;">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>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01 Utilization Management Program Description 2024.02 - pg. 15, Timeliness of UM Decisions</li> <li>LA.UM.05 Timeliness of UM Decisions and Notifications 08.16.2024 - pg. 3, Expedited / Urgent Decisions</li> <li>2024 UM Program Evaluation - pg. 10-11, Timeliness of UM Decision Making</li> <li>2024 LA Medicaid UM Notices TAT</li> <li>0188 Service Authorizations 2024 Q1 Submission Element 13,14,14,15,16,22</li> <li>0188 Service Authorizations 2024 Q2 Submission Element 13,14,15,16,22</li> <li>0188 Service Authorizations 2024 Q3 Submission Element 13,14,15,16,22</li> <li>0188 Service Authorizations 2024 Q4 Submission Element 13,14,15,16,22</li> </ul>	
<p><b>MCE Description of Process:</b> When the MCE receives an urgent request from the provider outlining that a member is encountering a medical or behavioral health issue that could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, we take the following actions: Triage these request to ensure they are given priority to ensure an expedited clinical review and if necessary, secondary advisor review. Notification of determination is sent to the member and provider as expeditiously as the member’s condition requires, but no later than 72 hours after the service authorization request is made.</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>15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if:</p> <p style="margin-left: 20px;">a. The member, or the provider, requests the extension; or</p> <p style="margin-left: 20px;">b. The MCE justifies to the State agency upon request a need for additional information and how the extension is in the member’s interest.</p> <p style="margin-left: 100px;">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><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 authorization request and date of the decision to extend the time frame</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>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 15, Timeliness of UM Decisions</li> <li>LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg. 3, Standard / Non-urgent Decisions; pg. 3, Expedited / Urgent Decisions</li> <li>2024 UM Program Evaluation - pg. 10-11, Timeliness of UM Decision Making</li> <li>0188_Service_Authorizations_2024 Q1 Submission Element 13,14,14,15,16,22</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 VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>0188_Service_Authorizations_2024 Q2 Submission Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q3 Submission Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q4 Submission Element 13,14,15,16,22</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE identifies or receives a request to extend a standard or expedited authorization timeframe. An extension may be granted for an additional 14 calendar days. LHCC has no record of requests on file to LDH to request any extension(s). LHCC does not have any case examples to provide in this instance. No requests for information resulted in a need to extend timeframe past the original 14 calendar days.</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>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="text-align: right;">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><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(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>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 15, Timeliness of UM Decisions</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: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6	<ul style="list-style-type: none"> <li>LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg. 3, Standard / Non-urgent Decisions</li> <li>2024 UM Program Evaluation - pg. 10-11, Timeliness of UM Decision Making</li> <li>0188_Service_Authorizations_2024 Q1 Submission Element 13,14,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q2 Submission_Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q3 Submission_Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q4 Submission_Element 13,14,15,16,22</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE after receiving approval of the extension from LDH will provide the member with a letter notifying them that their authorization request has been extended, as well as their right to file a grievance should they not agree with the extension. We will also carry out the determination of the extended service as expeditiously as the member’s health condition requires but no later than the date the extension expires. LHCC has no record of requests on file to LDH to request any extension(s). LHCC does not have any case examples to provide in this instance. No requests for information resulted in a need to extend timeframe past the original 14 calendar days. LHCC does not have an example of a letter to provide, however, can provide case examples in our clinical documentation 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>		
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><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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
<p>a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization.</p> <p style="text-align: right;">42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A)</p> <p>MCO Contract: None PAHP Contract: NA PIHP Contract: None</p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA_MCO_UM_Procedure</li> <li>UM_Monitoring</li> <li>UM5 Timeliness Report - LHCC 2024</li> <li>3 Case examples               <ul style="list-style-type: none"> <li>– PBM Request ID 000000061300102</li> <li>– PBM Request ID 000000059603321</li> <li>– PBM Request ID 000000063270583</li> </ul> </li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Monthly Pharmacy Report (RX055)</li> </ul>	
<p><b>MCE Description of Process:</b> As a result of LHCC’s contract with LDH, and subsequent contract with Prime Therapeutics, covered outpatient drug authorization decisions are delegated to Prime Therapeutics State Government Solutions, formerly known as Magellan Medicaid Administration (MMA), due to the LDH MCO contractual requirement of the state-mandated Single PBM Implementation, effective 10/28/23.</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>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;">42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c)</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> </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: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1	42 CFR §438.404(c)(1) 42 CFR §457.1230(d) <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> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</li> <li>LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg. 5, Written Notification for Medical Necessity Adverse Determination</li> <li>Member Denial_LA</li> <li>OP4096077945_Element 18</li> <li>OP4072115424_Element 18</li> <li>OP3858923715_Element 18</li> </ul>	
<p><b>MCE Description of Process:</b> If the MCE terminates, suspends, or reduces previously authorized services we follow our denial process, which includes notifying the member and provider of the denial via phone, fax, and/or via the online portal. In the notification, we would post date the services outlining an additional 10 days of approved services prior to the service authorization request ending. Case examples provider are OP4096077945_Element 18, OP4072115424_Element 18, OP3858923715_Element 18.</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>		
19. The MCE may send a notice not later than the date of action if: <ul style="list-style-type: none"> <li>a. The MCE has factual information confirming the death of a member;</li> </ul>	<b>HSAG Required Evidence:</b> <ul style="list-style-type: none"> <li>Policies and procedures</li> <li>UM program description</li> <li>ABD notice template(s)</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>b. The MCE receives a clear written statement signed by a member that:</p> <p style="margin-left: 20px;">i. The member no longer wishes services; or</p> <p style="margin-left: 20px;">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;</p> <p>c. The member has been admitted to an institution where the member is ineligible under the plan for further services;</p> <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; margin-right: 50px;">42 CFR §431.213            42 CFR §438.210(c)            42 CFR §438.404(c)(1)            42 CFR §483.15(b)(4)(i-ii)</p>	<ul style="list-style-type: none"> <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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</li> <li>LA.UM.07_Adverse_Determination_(Denial)_Notices_05.15.2024 - pg. 5, Written Notification for Medical Necessity Adverse Determination</li> <li>2024 Member Handbook - 19c, Pg.76, 3rd and 5th bullet, Involuntary Disenrollment for Cause</li> <li>Member Denial_LA</li> <li>LTC Member Case File - Std. VII Element 19</li> </ul>	



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Requirement	Supporting Documentation	Score
<p style="text-align: right;">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>MCE Description of Process:</b> The MCE makes every attempt to collect all necessary information to render an informed decision. Once a final decision has been rendered, notification to the member and provider is attempted within 10 days before the date of the proposed action or no later than the date of action. LHCC has provided a case example in the clinical documentation system and denial letter as shown in LTC Member Case File - Std. VII Element 19.</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>20. The MCE may shorten the period of advance notice to five days before the date of action if:</p> <p style="padding-left: 20px;">a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and</p> <p style="padding-left: 20px;">b. The facts have been verified, if possible, through secondary sources.</p> <p style="text-align: right;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</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>LA.UM.07_Adverse_Determination_(Denial)_Notices_05.15.2024 - pg. 5, Written Notification for Medical Necessity Adverse Determination</li> <li>Member Denial_LA</li> <li>SOP 5.1 Intake-Triage (Non-Rx) - entire document</li> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan - pg. 2, Policy; pg. 11, Reactive Referrals; pg. 12, FWA Email Box; pg. 13, Member Data Mining; pg. 14, Preliminary Review; pg. 15, Medical Record Sample Types.</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE would engage our Special Investigations Unit (SIU) upon suspecting or a report a member of fraudulent activity. Suspected fraudulent activity can be reported via a dedicated Fraud hotline, via company dedicated fraud email address, and a direct report from LDH. The SIU would investigate the case and would create a recommendation based on the information received from multiple sources. The findings will then be reported to our health plan compliance team to review and take necessary action(s) as necessary. The MCE will send a notice to the member within 10 days before the date of the proposed action. No instances of fraud were identified in the Louisiana Medicaid market during the 2024 calendar year, and as a result, no shortened-period advanced notice letters to a member were issued due to fraud.</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>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</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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
PIHP Contract: 11.3.3.1.4	<ul style="list-style-type: none"> <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>	
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.UM.07_Adverse_Determination_(Denial)_Notices_05.15.2024 - pg. 1, Definitions</li> </ul>	
<p><b>MCE Description of Process:</b> The MCE issues a denial letter based upon any adverse medical necessity determination, including any adverse determinations that would impact claims payments. LHCC does not have any claim payment denials that would have an ABD sent based on the claim denial process. If an authorization is required for the service and the authorization request was denied, the claim will adjudicate and deny then service for no authorization on file for the billed service. ABD is not required in this situation. The ABD would have already been sent to the provider based on the service authorization denial.</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>		
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.  <div style="text-align: right; margin-right: 50px;">             42 CFR §438.210(c-d)              42 CFR §438.404(c)(5)              42 CFR §457.1230(d)           </div>	<b>HSAG Required Evidence:</b> <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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard VII—Coverage and Authorization of Services		
Requirement	Supporting Documentation	Score
MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7	<ul style="list-style-type: none"> <li>Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice-risk</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>LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 16, Denial Notices</li> <li>LA.UM.05_Timeliness_of_UM_Decisions_and_Notifications_08.16.2024 - pg. 2, Timeliness of UM Decision Making and Notifications</li> <li>2024 UM Program Evaluation - pg. 9, Timeliness of UM Decision Making</li> <li>2024 LA Medicaid UM Notices TAT</li> <li>Member Denial_LA</li> <li>0188_Service_Authorizations_2024 Q1 Submission_Element 13,14,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q2 Submission_Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q3 Submission_Element 13,14,15,16,22</li> <li>0188_Service_Authorizations_2024 Q4 Submission_Element 13,14,15,16,22</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> The MCE reviewer does not administratively deny standard and expedited service requests not reached within the required timeframes. LHCC does not have any case examples for an untimely authorization decision within an ABD notice.</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>		
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;">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>• LA.UM.01_Utilization_Management_Program_Description_2024.02 - pg. 10, Affirmative Statement About Incentives</li> <li>• LA.UM.04_Appropriate_Utilization_Management_Professionals_07.09.2024 - pg. 4, Affirmative Statement About Incentives</li> <li>• LA.UM.04.01_Affirmative_Statement_About_Incentives_2024.02 - entire P&amp;P</li> <li>• LA Medicaid_WebSite_StatementOfIncentives</li> <li>• NCQA Affirmative Statement About Incentives Training Slide Deck &amp; Form</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 conducts a yearly training and attestation for all employees who conduct UM activities that outline that they will not receive incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member. Upon</p>		



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Requirement	Supporting Documentation	Score
completion of this training, each employee signs an affirmative statement to attest to this information. The health plan keeps a record of this information within the Ethics & Compliance team.		
<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 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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**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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.Cont.02-Network Selection and Retention – Page 1, Sections “Purpose,” Policy,” Procedure,” and k.</li> <li>• LA.Cred.01-Practitioner Credentialing and Recredentialing – Page 1, “Network Participation”</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> LA.Cont.02-Network Selection and Retention Policy and Procedure outlines and establishes guidelines that LHCC will select, recruit, and maintain provider’s membership in the provider network. Provider Network Engagement Specialists, Contracting, and Network Development selects and maintains a stable network via outreach, recruitment, and retention activities to ensure an adequate and accessible provider network. All providers will be required to be in accordance with 42 CFR §438.214 (LA.Cont.02-Network Selection and Retention, page 1). LHCC has developed and implemented policies and procedures for the acceptance of new providers screened, enrolled, and approved in writing by the State, and termination or suspension of providers to ensure compliance with the Contract (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 1).</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>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;">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>• LA.Cred.09-Organizational Assessment and Reassessment – Page 1 Section A</li> <li>• LA.Cont.02-Network Selection and Retention – Page 2 Section 3.</li> <li>• LA.Cred.01-Practitioner Credentialing and Recredentialing – Page 1 “Policy”</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> LHCC may include hospitals, home health agencies, skilled nursing facilities, federally qualified health centers, rural health clinics, laboratory testing/diagnostic facilities, rehabilitation centers and free- standing surgical centers; behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or in an ambulatory setting; and other atypical MLTSS providers including Home and Community Based Services (HCBS) and long-term care (LTC) institutional-based services Providers (LA.Cred.09-Organizational Assessment and Reassessment, page 1).</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</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> </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>that require costly treatment, consistent with 42 CFR §438.12.</p> <p style="text-align: right;">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>	<ul style="list-style-type: none"> <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>LA.Cont.02-Network Selection and Retention – Page 2, Section #3</li> <li>LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing – Page 1, “Policy,” Section I.a.i, and Section II.</li> <li>LA.Cred.01-Practitioner Credentialing and Recredentialing – Page 1, “Policy”</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Confidentiality Credentialing Committee NDA 2024 1</li> <li>Confidentiality Credentialing Committee NDA 2024 Template</li> </ul>	
<p><b>MCE Description of Process:</b> Credentialing and LHCC do not discriminate against providers that serve high-risk populations or specialize in the treatment of costly conditions (LA.Cont.02-Network Selection and Retention, page 2 &amp; LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing, page 1). All credentialing and recredentialing applications are processed in the same manner. To avoid discrimination, the Credentialing Committee participants must sign a non-discrimination form upon appointment. To monitor for discriminatory practices, there are established processes. If a practitioner or provider alleges discriminatory credentialing practices, credentialing reports to the Quality Improvement Committee and/or the Medical Director. Annually, the Credentialing Committee analyzes credentialing denials for any perceived patterns of potential discrimination. Any pattern that is identified is reported to the Quality Improvement Committee and/or the Medical Director (LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing, page 1).</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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.Cont.02-Network Selection and Retention – Page 1, Section K, Page 2, Section #3, Page 7, Section #48, Page 8, Section #59, and Page 12, Section #7.</li> <li>LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing – Page 1, Section I.A.i, Page 1 Section II, and Page 2, Section 1</li> <li>Individual executed agreement</li> <li>Organizational executed agreement</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.CRED07_Practitioner_Disciplinary_Action_and_Reporting_1.9.24 – Exhibit A-G</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> LHCC ensures it does not discriminate in the participation in the LHCC program, reimbursement, or indemnification against any provider solely on the provider’s type of licensure or certification (LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing, page 2 and LA.Cont.02-Network Selection and Retention, page 2). If LHCC declines to include providers in its network, a written notification is sent to LDH and a written notice to the affected provider of the reason(s) within fourteen calendar days of the decision to decline participation by the Provider Network Specialists and Contracting &amp; Network Development Departments (LA.Cont.02-Network Selection and Retention, pages 2, 7, 8, &amp; 12). A nondiscrimination statement form is signed by participants of the Credentialing Committee at the time of appointment. Mechanisms for monitoring for discriminatory practices include an annual review and analysis of credentialing denials for any perceived patterns of potential discrimination. If found, the patterns are reported to the Quality Improvement Committee and/or the Medical Director. Credentialing also reports to the Quality Improvement Committee and/or Medical Director any complaints received from practitioners or providers alleging discriminatory credentialing practices (LA.Cred.04-Nondiscriminatory Credentialing and Recredentialing, page 1). All providers are required to be in accordance with 42 CFR §438.214 (LA.Cont.02-Network Selection and Retention, page 1).</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;">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> <li>• Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity</li> </ul>	<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>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>LA.Cont.02-Network Selection – Pages 4-5, Sections #25 &amp; #26</li> <li>LA.Cred.01-Practitioner Credentialing and Recredentialing – Page 6 Section G; Page 9, Section VIII.A.vi ;Page 14, Section J</li> <li>FMOL Delegated Contract</li> </ul> <p><b>Additional Documentation</b>            Employee Screening Evidence:</p> <ul style="list-style-type: none"> <li>Employee Sanction_Exclusion Screening August 2024</li> <li>Employee Sanction Exclusion Screening September 2024</li> <li>Employee Sanction_Exclusion Screening October 2024</li> </ul> <p>Provider Screening Evidence:</p> <ul style="list-style-type: none"> <li>LA-Sanction Monitoring Grid-2024</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC will not pay claims to or execute contracts with providers who have been excluded from participation in Federal health care programs under either 42 U.S.C. §1320a-7 or §1320a-7a [42 C.F.R. §438.214(d)] or state funded health care programs. LHCC will use a list of providers excluded from federally funded health care programs using the sources provided in the MCO Manual (LA.Cont.02-Network Selection and Retention, page 5). This is a minimum administrative requirement in the credentialing process and if the provider is found to be excluded from participation in the federal health care programs, the process is terminated and is referred to as “administrative” termination of the application process (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 9). Pursuant to Section 1128 of the Social Security Act, LHCC does not contract or shall terminate contracts with providers who have been excluded from participation in the Medicare and/or Medicaid program (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 14).</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.		
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 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</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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 14 Section XVI subsection I and M</li> <li>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 6 Section II subsection E</li> <li>• LA.COMP.16-Fraud, Waste, and Abuse Plan – Page 7 Section 7 &amp; Page 8 Sections 11 &amp; 3</li> <li>• 148 LHCC 2024 10 Signed Integrity AT</li> <li>• 148 LHCC 2024 11 Signed Integrity AT</li> <li>• 148 LHCC 2024 12 Signed Integrity AT</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• To ensure compliance with contractual requirements, monthly screenings are conducted to verify that all providers are not listed on any</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p><i>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>PIHP:</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 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>debarment, suspension, or exclusion lists. Upon completion of each screening, the designated LHCC business owner submits the finalized report to the Compliance Department via Archer. Based on the business owner’s attestation to the accuracy and completeness of the report, the Contract Compliance Officer then prepares the Medicaid Program Integrity Attestation for the Medicaid CEO’s signature.</p>	
<p><b>MCE Description of Process:</b> LHCC 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. All exclusions found are to be reported to LDH within three business days. LHCC, through its Contract Compliance Officer, shall attest monthly to LDH that it has screened all providers or has verified and confirmed that the provider is enrolled with the State. LHCC shall report to LDH within three business days when it has discovered that any LHCC employee(s), Network Provider, subcontractor, or subcontractor’s employee(s) have been excluded, suspended, or debarred from any state or federal health care benefit program (LA.Comp.16-Fraud, Waste, and Abuse Plan, pages 7 &amp; 8). LHCC provides a program integrity attestation monthly for the screening of providers, employees,</p>		



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<p>and subcontractors. A search is conducted on the OIG list of excluded individuals/entities, Louisiana Adverse Actions List Search, System of Award Management, and other applicable sites as determined by LDH (148 LHCC 2024 Signed Integrity AT). LHCC will report to LDH any participating providers who have been terminated due to exclusion within 3 business days (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 14).</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="margin-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; margin-right: 20px;">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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.01-Practitioner Credentialing and ReCredentialing – Page 1, “Policy”; Page 4, Section II, subsection A and Page 8, Section VI.</li> <li>• LA.Cont.02-Network Selection and Retention – Page 4 Section 20</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> A complete application contains all information needed for credentialing to review, including current application attestations, aged not more than 180 days from anticipated credentialing decision. LHCC uses the state license or certification agency (or its website) to verify the practitioner’s current and valid license at the time of credentialing decision. The validity of the license is required in all states the practitioner provides care to LHCC members (LA.Cred.01-Practitioner Credentialing and Recredentialing, pages 4 &amp; 8).</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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<b>Practitioner Verification of Credentials</b>		
<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>LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 6 Section III Subsection B and C</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> For those qualified to write prescriptions, credentialing verifies the practitioner’s Drug Enforcement Administration (DEA) certificate through current certificates, the DEA Diversion website, NTIS, or an AMA profile. LHCC requires verification of the LA controlled dangerous substance certificate, if applicable, via current copy of the certificate or primary source verification (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 6).</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. 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</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>LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 4 Section II subsection B paragraph i</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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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> Credentialing verifies the highest of the three levels of education and training obtained by the practitioner (graduation from medical school, residency, or board certification).		
<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>a. <i>Verification of board certification does not apply to nurse practitioners (NPS) or other health care 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>	<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>• LA.CRED.01-Practitioner Credentialing and ReCredentialing – Page 8 Section VI subsection A and paragraph C and Page 5 &amp; 6 Section II subsection C</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> : A complete application contains all information needed for credentialing to review, including current application attestations, aged not more than 180 days from anticipated credentialing decision (LA.Cred.01-Practitioner Credentialing and ReCredentialing, page 8). If the practitioner claims to be board certified, Credentialing verifies current board certification. Their board certification expiration date is documented in the credentialing file unless the certification does not expire. The lifetime certification status is verified and documented. If the medical board does not provide the expiration date, Credentialing verifies that the board certification is current and documents the date of verification (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 5 & 6).		
<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>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>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>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 7 Section III subsection F</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> LHCC performs a work history review and the results of the review are documented within the credentialing file. Relevant work history, as a health professional, is obtained through the practitioner’s application or Curriculum Vitae (CV). Work history is to be submitted in a month/year format for at least the preceding five years. If a gap in employment exceeds six months, it is clarified either verbally or in writing and documented in the credentialing file. If a gap in employment exceeds one year, it will be clarified in writing. If the practitioner has fewer than five years from the date of verification in relevant work history, the time frame starts at the time of initial licensure. Experience practicing as a non-physician health professional within the five years should be included (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 7).</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>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.</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 6 Section II subsection D paragraph ii and Page 8 Section VI subsection A</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> A complete application contains all information needed for credentialing to review, including current application attestations, aged not more than 180 days from anticipated credentialing decision (LA.Cred.01-Practitioner Credentialing and ReCredentialing, page 8). For report(s) of malpractice settlement(s), Credentialing reviews the history of all settled malpractice claims against a practitioner within the past five years from date of report, or as defined by the unique LHCC look back period (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 6). Reports of malpractice settlements requires a review of the National Practitioner Data Bank (NPDB) and Credentialing reviews of the history of all settled malpractice claims against a practitioner within the past five years from date of report, or as defined by the unique LHCC look back period (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 6).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one practitioner initial credentialing file and one practitioner recredentialing file did not verify compliance with primary source verification documentation requirements.</p>		
<p><b>Required Actions:</b> For credentialing and recredentialing, the MCE must verify 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.</p>		



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Requirement	Supporting Documentation	Score
<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>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;">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>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 4 Section A paragraph ii and Page 8 Section VI subsection A</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> A complete application contains all information needed for credentialing to review, including current application attestations, aged not more than 180 days from anticipated credentialing decision (LA.Cred.01-Practitioner Credentialing and ReCredentialing, page 8). A verification for state sanctions, restrictions on licensure and limitations on scope of practice of the most recent five year period available through the a query of the National Practitioner Data Bank or with the applicable Sate Licensure Board or the applicable state certification board or state agency is performed (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 4).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for three practitioner recredentialing case files and five organizational recredentialing files did not verify compliance with primary source verification requirements. More specifically, the case files did not include verification of the Louisiana Adverse Actions List.</p>		
<p><b>Required Actions:</b> For credentialing and recredentialing, the MCE must verify the State sanctions, restrictions on licensure, and limitations of scope of practice within 180 days of the credentialing decision. Additionally, the MCE must verify in all states where the practitioner provides and/or provided care to members within the most recent five-year period available.</p>		



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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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 4 Section A paragraph ii, Page 8 Section VI, and Page 9 Section IX Subsection A paragraph iv</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> A complete application contains all information needed for credentialing to review, including current application attestations, aged not more than 180 days from anticipated credentialing decision (LA.Cred.01-Practitioner Credentialing and ReCredentialing, page 8). The determination of a clean file is defined as one that has no past or present Federal or State sanction activity including Medicaid sanctions (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 9).</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> </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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 6 Section III subsection A</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p>f. <i>Current and signed attestation confirming the correctness and completeness of the application.</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>		
<p><b>MCE Description of Process:</b> A complete application form includes a signed attestation from the applicant for correctness and completeness of the application. Attestation elements include reasons for inability to perform the essential functions of the position, with or without accommodation; physical or mental health problems that may affect the provider’s ability to provide health care; lack of present/current illegal drug use; history of chemical dependency/substance abuse; history of loss or limitation of license and/or felony convictions; history of loss or limitation of clinical privileges and/or disciplinary actions; and current malpractice insurance coverage (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 6).</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. One practitioner initial credentialing case file and one practitioner recredentialing case file did not verify compliance with current malpractice insurance coverage. The case files contained malpractice insurance information; however, evidence of current malpractice coverage obtained through verification was not included.</p>		
<p><b>Required Actions:</b> For credentialing and recredentialing, the MCE must include evidence of current malpractice coverage obtained through verification.</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>	<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>



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Requirement	Supporting Documentation	Score
<p>a. <i>Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);</i></p> <p>b. <i>Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and</i></p> <p>c. <i>Implementing appropriate interventions when it identifies instances of poor quality.</i></p> <p style="text-align: right;">2 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>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.06-Ongoing Monitoring of Sanctions and Complaints – Pages 1-2 Section B</li> <li>• Provider Complaints Tracking – 2024</li> <li>• 2024 BH PQM Scorecard 1</li> <li>• 2024 BH PQM Scorecard 2</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LA.CRED.06_Ongoing_Monitoring_of_Sanctions_and_Complaints_11.2024</li> <li>• LHCC Credentialing Committee Minutes 6.26.2024</li> </ul>	
<p><b>MCE Description of Process:</b> Credentialing refers any incidences of possible poor quality of care to QI so important quality or safety issues are identified and addressed. LHCC evaluates the history of all practitioner-specific complaints for all practitioners and adverse events and/or significant trends in type or volume of complaints for a particular practitioner every six months. Complaints are reviewed, categorized, and leveled by QI. Further investigation will occur for practitioners identified as meeting a threshold of three or more complaints and/or adverse events in a six-month period. Appropriate action is taken if evidence of poor quality that could affect the health and safety of members is identified, including for practitioners not meeting the threshold, dependent on the severity of the identified issue(s). The evaluation of complaints and sentinel/adverse events get sent to Credentialing for review and follow-up as indicated. Information may be presented in the form of a checklist, log, or report. The findings and follow up action are reported at the next Credentialing Committee meeting and recorded in committee minutes, credentialing files and other documentation of actions taken against a practitioner (LA.Cred.06-Ongoing Monitoring of Sanctions and Complaints, pages 1-2).</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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Standard VIII—Provider Selection		
Requirement	Supporting Documentation	Score
<b>Organizational Verification of Credentials</b>		
<p>17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies.</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>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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CRED.01-Practitioner Credentialing and ReCredentialing – Page 1 Section POLICY and Page 6 Section II subsection G</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.CRED.09_Organizational_Assessment_and_Reassessment_06.11.24</li> <li>Louisiana State License Websites 2024</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> For credentialing and recredentialing, LHCC established standards for provider selection and retention. These standards include ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 1). LHCC verifies and determines if a practitioner has been debarred, suspended, or otherwise excluded from participating in federal procurement activities under the Feral Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 6).</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>18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body.</p> <p style="margin-left: 20px;">a. <i>If the provider is not accredited, the MCE conducts an onsite quality assessment.</i></p> <p style="margin-left: 40px;">i. <i>The MCE has a process for ensuring that the provider credentials their practitioners.</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: 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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CRED.01-Practitioner Credentialing and ReCredentialing Page 1 Section POLICY (first paragraph)</li> <li>LHCC Facility Site Visit Form</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> For credentialing and recredentialing, LHCC established standards for provider selection and retention. These standards include ongoing monitoring that meet the qualifications of applicable state and federal government regulations, applicable standards of accrediting bodies, including the National Committee for Quality Assurance (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 1).</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>		
Time Frames		
<p>19. The MCE ensures that the credentialing process provides for mandatory recredentialing 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>Recredentialing timeliness report during the review period</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</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.Cred.01-Practitioner Credentialing and Recredentialing – Page 2, Section 9, “Recredentialing.”</li> <li>LA.Cred.09-Organizational Assessment and Reassessment – Page 1, Section C</li> <li>LA Recred KPIs January-December 2024</li> </ul>	
<b>MCE Description of Process:</b> LHCC ensures practitioners and providers are recredentialing at least every 36 months. The reassessment cycle begins with the date of the initial credentialing decision (LA.Cred.01-Practitioner Credentialing and Recredentialing, page 2, and LA.Cred.09-Organizational Assessment and Reassessment, page 1).		
<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	=	16	X	1	=	16
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	19	<b>Total Score</b>	=		16

<b>Total Score ÷ Total Applicable</b>	=	<b>84%</b>
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### 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>• VM Program Description 2024, top of Page 2</li> <li>• CC.COMP.60, Page 3 under Relationship Managers</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC’s Vendor Management Program Description is reviewed and approved every year in the Vendor Management Committee, which has representation from all business areas. This describes the process for managing and monitoring our vendors. Additionally, CC.COMP.60 is our Corporate enterprise-wide policy regarding the monitoring of vendors and who is ultimately responsible.</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>Contract or Written Arrangement</b>		
<p>2. Each contract or written arrangement with a delegate must specify:</p> <p style="margin-left: 20px;">a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.</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> <ul style="list-style-type: none"> <li>• DSA Template – 2024-01.1, Page 4 Section 3.5, Page 5 Section 4</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE’s contract obligations.</p> <p>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.</p> <p style="text-align: right;">42 CFR §438.230(b)(2)            42 CFR §438.230(c)(1)            42 CFR §457.1233(b)</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>	<ul style="list-style-type: none"> <li>Louisiana Subcontractor Product Attachment, Page 9 Section 18</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>MRIoA_CSA_Amendment-effective 05.22.2024</li> </ul>	
<p><b>MCE Description of Process:</b> All agreements with delegated vendors utilize Centene’s Delegated Services Agreement template. Additionally, all Louisiana vendors incorporate the Louisiana Product Attachment with the required language. Vendors are not permitted to move forward in the process if they are unable to add the Product Attachment. All agreements are also reviewed and approved by internal leadership to verify they meet state 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>		
<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</p> <p>MCO:</p> <p>a. <i>rules, policies, procedures, manuals, the State Plan, and Waivers.</i></p> <p style="text-align: right;">42 CFR §438.230(c)(2)</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> <ul style="list-style-type: none"> <li>DSA Template – 2024-01.1, Page 1 Section 1, Page 2 Section 2</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 IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p style="text-align: right;">42 CFR §457.1233(b)</p> <p>MCO Contract: 2.2.3.4.4            PAHP Contract: 2.15.6.3            PIHP Contract: 1.5.3.1</p>	<ul style="list-style-type: none"> <li>Louisiana Subcontractor Product Attachment, Page 8 Section 10</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>MRIoA_CSA_Amendment-effective 05.22.2024</li> </ul>	
<p><b>MCE Description of Process:</b> All agreements with delegated vendors utilize Centene’s Delegated Services Agreement template. Additionally, all Louisiana vendors incorporate the Louisiana Product Attachment with the required language. Vendors are not permitted to move forward in the process if they are unable to add the Product Attachment. All agreements are also reviewed and approved by internal leadership to verify they meet state requirements.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC provided the Delegated Services Agreement and Louisiana Subcontractor Product Attachment templates for review. LHCC’s Louisiana Subcontractor Product Attachment template included a provision requiring that subcontractors “ comply with all applicable State Contract requirements, applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and applicable sub-regulatory guidance (SC §2.2.3.4.4).” LHCC’s delegation file submissions were also used by the HSAG reviewer to evaluate this requirement. LHCC’s executed contracts and addenda for all three delegation file review submissions contained the same or similar language except for one submission. LHCC’s submissions did not comport with the required federal and State language of this requirement, 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, records, contracts, computer or other electronic systems of the delegate, or of the delegate's subcontractor, that pertain to any aspect of services and</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> <ul style="list-style-type: none"> <li>Louisiana Subcontractor Product Attachment, Page 5 Section 16, Page 9 Section 13</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 IX—Subcontractual Relationships and Delegation		
Requirement	Supporting Documentation	Score
<p>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;">42 CFR §438.230(c)(3) 42 CFR §457.1233(b)</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>	<p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• MRIOA_CSA_Amendment-effective 05.22.2024</li> </ul>	
<p><b>MCE Description of Process:</b> All Louisiana vendors incorporate the Louisiana Product Attachment with the required language. Vendors are not permitted to move forward in the process if they are unable to add the Product Attachment. All agreements are also reviewed and approved by internal leadership to verify they meet state requirements.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC provided a Subcontractor Product Attachment template for review. For sub-elements 4a and 4b, LHCC’s Louisiana Subcontractor Product Attachment template included language that did not comport with the required federal and State language of this requirement, which is exacting. For sub-elements 4c and 4d, LHCC’s Louisiana Subcontractor Product Attachment template included language that was sufficient to comply with the required federal and State</p>		



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Requirement	Supporting Documentation	Score
<p>language of this requirement. LHCC’s delegation file submissions were also used by the HSAG reviewer to evaluate this requirement. LHCC’s submissions did not comport with the required federal and State language of this requirement, which is exacting for sub-elements 4a and 4b.</p>		
<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:  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></p> <p style="text-align: right;">42 CFR §438.230  42 CFR §457.1233(b)</p> <p>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>• Louisiana Subcontractor Product attachment, Page 6, Item #30</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• MRIOA_CSA_Amendment-effective 05.22.2024</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> All Louisiana vendors incorporate the Louisiana Product Attachment with the required language. Vendors are not permitted to move forward in the process if they are unable to add the Product Attachment. All agreements are also reviewed and approved by internal leadership to verify they meet state requirements.</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 action required.		
Monitoring and Auditing		
<p>6. Monitoring subcontractor’s performance shall be monitored:</p> <p>MCO:</p> <p style="margin-left: 20px;">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 style="margin-left: 20px;">a. <i>On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.</i></p> <p>PIHP:</p> <p style="margin-left: 20px;">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; margin-right: 20px;">42 CFR §438.230 42 CFR §457.1233(b)</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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Louisiana Subcontractor Product attachment, Page 9, Item #16, Page 9 Item #18</li> <li>VM Program Description 2024, Page 4</li> <li>MMA JOC Meeting Minutes 4.29.2024</li> <li>Magellan Rx 2024 TPRMO Annual Audit Results Summary_Redacted</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 Audit Results Summary BR Printing 10.28.2024</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 Louisiana vendors incorporate the Louisiana Product Attachment with the required language. Vendors are not permitted to move forward in the process if they are unable to add the Product Attachment. All agreements are also reviewed and approved by internal leadership to verify they meet state requirements. The VM Program Description describes the Vendor Management program and the process for auditing and monitoring vendors. National vendors are audited by corporate whereas local vendors are audited locally. We also</p>		



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Requirement	Supporting Documentation	Score
monitor vendors in our Joint Operational Committee meetings (held a minimum of quarterly for delegated vendors) and have supplied a copy of the Results summary from a recent audit for Prime Therapeutics (formerly known as Magellan Rx or Magellan Medicaid Administration).		
<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 IX—Subcontractual Relationships and Delegation							
<b>Total</b>	Met	=	4	X	1	=	4
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>		=	6	<b>Total Score</b>		=	4

<b>Total Score ÷ Total Applicable</b>	=	<b>67%</b>
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**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>LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 – Page 1</li> <li>LHCC Adopted Clinical Practice and Preventive Health Guidelines 5.24 (Full document)</li> <li>March 2024 PH Survey with Comments</li> <li>Clinical, Payment, Phar Policy workgroup minutes 5.28.24</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> Louisiana Healthcare Connections (LHCC) adopts clinical practice guidelines through its internal Policy Review Committee and Clinical Advisory Committee. Guidelines are based on recognized sources such as SAMHSA, AAP, CDC, USPSTF, and relevant literature. Policies are reviewed and approved with stakeholder input and updated periodically. March 2024 PH Survey with Comments demonstrates approval of CP.CPC.03 through survey on March 21, 2024. Policy was then reviewed and approved in the Health Plan Clinical, Payment, Phar Policy workgroup as shown in document Clinical, Payment, Phar Policy workgroup minutes 5.28.24</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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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<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> <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> <p>a. develops clinical practice guidelines for:</p> <ul style="list-style-type: none"> <li>i. ADHD</li> <li>ii. Trauma Informed Care</li> <li>iii. Depression and Conduct Disorder</li> </ul> <p style="text-align: right;">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>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>• LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 – Page 1, Page 3</li> <li>• Adopted Clinical Practice and Preventive Health Guidelines – Pages 14 - 19</li> <li>• March 2024 PH Survey with Comments</li> <li>• Clinical, Payment, Phar Policy workgroup minutes 5.28.24</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 X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b> Guidelines are selected based on high-prevalence behavioral health conditions affecting our population, including ADHD, depression, substance use disorders, PTSD, and ODD. LHCC evaluates needs through claims analysis, member input, and clinical team review. We ensure condition-specific policies are adopted for youth and adult populations as required. March 2024 PH Survey with Comments demonstrates approval of CP.CPC.03, including Adopted Clinical Practice and Preventive Health Guidelines, through survey on March 21, 2024. Policy and guidelines were then reviewed and approved in the Health Plan Clinical, Payment, Phar Policy workgroup as shown in document Clinical, Payment, Phar Policy workgroup minutes 5.28.24</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 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>• LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 (page 1, Section I.A.2.)</li> <li>• March 2024 PH Survey with Comments</li> <li>• Clinical, Payment, Phar Policy workgroup minutes 5.28.24</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> All practice guidelines are reviewed and adopted in consultation with physicians. Recommendations and feedback from behavioral health providers and medical directors are documented in committee meetings. March 2024 PH Survey with Comments documents the physician reviews and comments brought to the committee for review 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>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<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 style="margin-left: 20px;">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; margin-right: 20px;">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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 – Page 1</li> <li>LA.COMP.76_Policy_Procedure_Guidelines_6.11.24 - Page 1</li> <li>Clinical, Payment, Phar Policy workgroup minutes 5.28.24</li> <li>March 2024 PH Survey with Comments</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> Policies are reviewed annually and revised, as necessary. All final adopted and revised guidelines are submitted to LDH for review and approval. Revisions reflect updated evidence and provider feedback. Version control is maintained on each policy. CP.CPC.03 was reviewed through a survey in March at the corporate level through email sent on March 21, 2024. Document March 2024 PH Survey with Comments demonstrates the review and approval of the policy revisions. LHCC adopted the policy revisions during the May 2024 Clinical/Payment/Pharmacy Policy Workgroup as noted in document Clinical, Payment, Phar Policy workgroup minutes 5.28.24.</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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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<b>Dissemination of Guidelines</b>		
<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="margin-left: 40px;">42 CFR §438.236(c)</p> <p style="margin-left: 40px;">42 CFR §457.1233(c)</p> <p>MCO Contract: 2.12.12.5</p> <p>PAHP Contract: 2.5.5.3</p> <p>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><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 - page 2</li> <li>2024 Provider Manual Section Clinical Practice Guidelines – Page 9, Page 85</li> <li>LHCC website-member resources</li> <li>LHCC Provider Website – Practice Guidelines</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> LHCC disseminates adopted practice guidelines to providers via the provider manual, and provider newsletters which are located within our online portal, under QI program. Members are informed via the Member Handbook and within our online portal under Member resources. Additional copies can be provided upon 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>		



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Standard X—Practice Guidelines		
Requirement	Supporting Documentation	Score
<b>Application of Guidelines</b>		
<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;">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>LA.CP.CPC.03c - Preventive Health and Clinical Practice Guidelines 5.24 - page 1</li> <li>LA.CP.CPC.05 Medical Necessity Criteria 9.24 – Page 1</li> <li>Coverage denial notice examples</li> <li>Understanding Anxiety educational guidance from Krames 2024</li> <li>LHCC website-member resources</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> LHCC applies clinical guidelines to utilization management determinations, care coordination, and member education. Medical Directors will consider reports for peer reviewed medical literature, i.e., adopted practice guidelines, if no other guidance as stated is A through E of LA.CP.CPC.05 Medical Necessity Criteria 9.24 is applicable. Member materials and handbook clearly reflect coverage rules tied to these standards.</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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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**  
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**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;">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>• Centene System Narrative</li> <li>• Centene System Diagram</li> <li>• D.1_1.1.3.1_Authorization_Intake_Workflows 1</li> <li>• Trucare_Systems Interfaces</li> <li>• DataInterfaces_HL_ArchView_Presentation</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 XI—Health Information Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>CC.INFOSEC.06.00_Information Security Compliance Policy</li> <li>LA.CLMS.04_Claims_Management_Reporting_and_Auditing</li> <li>010 Instructions</li> <li>409 Instructions document</li> <li>010 and 409 Step-by-Step Guide</li> <li>Disenrollment Codes - Excerpt Appendix D of Technical Manual - Medical Companion Guide</li> <li>Disenrollments Process Flow Chart</li> <li>Maximus Guide - Disenrollment Tasks Procedure – Plans</li> <li>Policy - LA.ELIG.02_Disenrollment_5.13.25</li> <li>Technical Manual LHCC - LA Enrollment Summary V2.14</li> <li>Technical Manual Maximus - Manual Corrections File Layout-Data Dictionary MCO2</li> <li>Technical Manual Maximus - Medical Companion Guide_Companion_Guide_5-19-25_v2.57</li> <li>Screenshot Disenrollment Codes Available In Query System</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>D.1_1.1.3.1_Authorization_Intake_Workflows 1</li> <li>CCIT03_V29_Backup Policy</li> </ul>	



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Requirement	Supporting Documentation	Score
<p><b>MCE Description of Process:</b></p> <p>A. Louisiana Healthcare Connections (LHCC) utilizes TruCare platform for prior authorization and pre-certification reviews as outlined in D.1_1.1.3.1_Authorization_Intake_Workflows 1. Trucare_Systems Interfaces document illustrates how utilization management data flows through the HIS.</p> <p>B. Through the file communication component of our MIS we support file exchanges with external entities, including daily and monthly HIPAA 834 enrollment and eligibility, encounter reporting data, Provider files and more. We use transaction management software to handle our automated file exchanges (transmission and receipt) with the State Agency. We can support all standard industry data communication protocols (including Secure FTP). We protect our file exchanges with access control, authentication, and secure configuration features for total data integrity protection during transmission. From an internal data networking perspective, our network backbone is highly redundant through a mesh design that provides multiple paths to and from each point, allowing maximum network availability for the Health Plan and Centene, and enabling us to meet file transmission and receipt schedules as required by State. We also utilize our Diplomat Controls Dashboard, which provides us with full end-to-end visibility into critical file transfers, and allows us to fully manage our file transfer environment. Through the dashboard, we are able to drill down into file transfers for real-time visibility of job scheduling and success, enabling a more rapid response to file transfer failures and delivery.</p> <p>C. LHCC Grievance and Appeals Teams employ a SharePoint site where a tracking log has been built to house all regulatory and contractual elements in addition to management oversight tools related to member grievances and appeals. The data required by the monthly state reports (LA 010 and LA 409) are extracted from the SharePoint site and imported into an Excel worksheet that mimics the state reports. Once proofread, the information is copied and pasted into the state reports where it is summarized, sorted and categorized for trend analysis and submission.</p> <p>D. Disenrollments are received via the 834 file (See Technical Manual Maximus - Medical Companion Guide_Companion_Guide_5-19-25_v2.57 page 17). Disenrollments are not the decision of LHCC – if a member requests disenrollment outside of the standard open-enrollment or State reviews, this request is made to the Medicaid Office and the requests status is tracked by Maximus the Enrollment Broker – see files “Disenrollments Process Flow Chart” for high level overview of delineation of Disenrollment Process and see file “Maximus Guide - Disenrollment Tasks Procedure – Plans” for the technical guidance provided to the health plans on how to review and offer feedback to Maximus/LDH. This feedback though is supplemental. The feedback does not determine enrollment or disenrollment. That decision is made at the State level. Once Disenrollment occurs Maximus (the enrollment broker) sends LHCC a disenrollment 024 code with the Disenrollment Closure reason (for an excerpt of the disenrollment closure reasons see file “Disenrollment Codes - Excerpt Appendix D of Technical Manual - Medical Companion Guide”. While LHCC does not receive the disenrollment until it is ready to be processed, we ingest disenrollment (024 Termination Maintenance codes) as received and ingest the disenrollment reason codes into our database (to be pullable for reporting or any other operational needs). Maximus Enrollment Broker sent 834 files are ingested within 24 hours of receipt. To see how Disenrollment codes</p>		



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<p>can be referenced / pulled after ingestion into LHCC’s Systems see file “Screenshot Disenrollment Codes Available In Query System.” (in this screenshot I’ve highlighted the end/disenrollment date and the closure code attribute and the closure reason description attribute). The Query within the screenshot references any member without a Null value for the Closure codes (i.e., pulls in all closure codes). For accurate ingestion of Closure codes and any other attribute updates, we rely on the accuracy of the 834 files from the state designated Enrollment Broker and the guidance on how to ingest those files as outlined in the Technical Manuals included as evidence here. The specific sections related to Disenrollment are pulled out in “Disenrollment Codes - Excerpt Appendix D of Technical Manual - Medical Companion Guide” and in page 17 of the file “Technical Manual Maximus Medical Companion Guide” (regarding Maintenance Codes that trigger and Add, Update or Term). From a LHCC standpoint all TERMS are managed the same way analytically (Maximus sends LHCC an 024 code with a closure code on a daily 834 file, LHCC ingests that code to complete the term per the Maximus designated Term date).</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>		
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;">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><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>• LA.CLMS.06 - Claims Management – Functionality</li> <li>• WF.LA.Encounter</li> <li>• LA.ENC.01 Encounter Data Policy and Procedures_LHCC</li> </ul>	



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	<b>Additional Documentation:</b> <ul style="list-style-type: none"> <li>Please see link to the LDH website: <a href="https://ldh.la.gov/medicaid/mce-system-companion-guide">https://ldh.la.gov/medicaid/mce-system-companion-guide</a></li> </ul>	
<b>MCE Description of Process:</b> LHCC maintains an electronic claims management system that identifies all data elements as required by LDH for encounter data submission as stipulated in the Contract and the MCO System Companion Guide.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
3. The MCE ensures that data received from providers is accurate and complete by: <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 State Medicaid quality improvement and care coordination efforts.</li> </ol> <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>	<b>HSAG Required Evidence:</b> <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> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.CLMS.05 – Encounter Data</li> <li>CC.CLMS.10 - Claims Processing</li> <li>LA.CLMS.07 -Claims Management Payment to Providers</li> <li>221 LHCC 2024 12 - Timeliness Report</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> LHCC identifies all data elements as required by LDH for Encounter Data submission as stipulated in the MCO System Companion Guide; Accept submission of electronic adjustment and void transactions.		



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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.		
<p>4. The MCE makes all collected data available to the State and upon request to CMS.</p> <p style="text-align: right;">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></p> <ul style="list-style-type: none"> <li>• LA.CLMS.04_Claims_Management_Reporting_and_Auditing</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC shall provide to state auditors (including legislative auditors), or their designee, upon written request, files for any specified accounting period that a valid Contract exists in a file format or audit defined media, magnetic tapes, CD, or other media compatible with LDH and/or state auditor’s facilities. LHCC shall provide information necessary to assist the state auditor in processing or utilizing the files. LHCC shall coordinate audits with the Department or designee and respond within thirty (30) calendar days of a request by the Department regarding the PLAN’s review of a specific provider and/or claim(s), and the issue reviewed.</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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<b>Claims Processing</b>		
<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>MCO Contract: 2.18.1.1            PAHP Contract: 2.14.2.1.3; 2.14.2.1.4            PIHP Contract: 15.2.2.7</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>LA.CLMS.06 – Claims Management – Functionality</li> <li>LA.CLMS.04_Claims_Management_Reporting_and_Auditing</li> <li>CC.INFOSEC.06.00_Information Security Compliance Policy</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC maintains an electronic claims management system that identifies all data elements as required by LDH for encounter data submission as stipulated in the Contract and the MCO System Companion Guide.</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>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</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> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p>to its current members or the members’ personal representatives through the API as follows:</p> <p>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;</p> <p>b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments;</p> <p>c. All other encounter data, including adjudicated claims and encounter data from any subcontractors.</p> <p>d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE;</p> <p>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.</p> <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>MCO Contract: None            PAHP Contract: None            PIHP Contract: None</p>	<ul style="list-style-type: none"> <li>List of registered third-party applications</li> <li>HSAG will use the results from the API demonstration</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>2025 HSAG Audit - Louisiana Healthcare Connections - Interoperability</li> <li>Direct Link to the Patient Access API Documentation page: <a href="https://partners.centene.com/apiDetail/2718669d-6e2e-42b5-8c90-0a82f13a30ba">https://partners.centene.com/apiDetail/2718669d-6e2e-42b5-8c90-0a82f13a30ba</a></li> <li>Louisiana Healthcare Connections’ member Interoperability education web page: <a href="https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access.html">https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access.html</a></li> <li>Louisiana Healthcare Connections’ developer Interoperability education web page: <a href="https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access/interoperability-for-developers.html">https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access/interoperability-for-developers.html</a></li> <li>The list of these connected applications is available to the public at this URL: <a href="https://partners.centene.com/applicationDeveloper#connectedapplications">https://partners.centene.com/applicationDeveloper#connectedapplications</a></li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections’ parent company, Centene, has onboarded OneRecord, Flexpa, and b.Well as Third-Party Application Developers. We continue to work with the onboarded applications to resolve any identified issues or concerns. We also continue to work with other Third-Party Application Developers for future access.</p>		



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<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 LHCC 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 §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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2025 HSAG Audit - Louisiana Healthcare Connections - Interoperability</li> <li>• Direct Link to the Provider Directory API Documentation page:  <a href="https://partners.centene.com/apiDetail/8122bc9c-43d6-4a2a-b6be-2272df8b8566">https://partners.centene.com/apiDetail/8122bc9c-43d6-4a2a-b6be-2272df8b8566</a></li> <li>• Louisiana Healthcare Connections’ member Interoperability education web page:  <a href="https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access.html">https://www.louisianahealthconnect.com/members/medicaid/resources/interoperability-and-patient-access.html</a></li> <li>• Louisiana Healthcare Connections’ developer Interoperability education web page:  <a href="https://www.louisianahealthconnect.com/membe">https://www.louisianahealthconnect.com/membe</a></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><a href="https://rs/medicaid/resources/interoperability-and-patient-access/interoperability-for-developers.html">rs/medicaid/resources/interoperability-and-patient-access/interoperability-for-developers.html</a></p> <ul style="list-style-type: none"> <li>The list of these connected applications is available to the public at this URL:  <a href="https://partners.centene.com/applicationDeveloper#connectedapplications">https://partners.centene.com/applicationDeveloper#connectedapplications</a></li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.MBRS.30_Provider_Directory_and_Electronic_Files_from_Portico_12.2024</li> <li>LA.MRKT.14_Provider_Directory_for_Members_12.24</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections' parent company, Centene, built a centralized payer data management façade to enable the efficient sharing of Provider Directory information. The centralized payer data façade is comprised of a real-time Provider data repository (data lakes) that stores ready-access data that is used to provide data to the Provider Directory FHIR-based API.</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>		



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Requirement	Supporting Documentation	Score
<b>Member Encounter Data</b>		
<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; 15.2.2.9</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>LA.ENC.01 Encounter Data Policy and Procedures_LHCC</li> <li>LHCC- Encounter - Rendering &amp; line service item -Examples</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> EDM is our workflow-enabled encounter reporting system that translates claims data into HIPAA compliant 837 transactions that conform to LDH specific content and transmission specifications. Because EDM is an integrated component of our MIS, member and provider data elements will match the State’s eligibility and provider files sent to us by 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>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><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>Policies, procedures, and workflows</li> <li>Encounter data submission requirements</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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<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>PIHP:</p> <p>a. <i>Submit complete and accurate encounter data at least weekly</i></p> <p style="text-align: right;">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>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>LA.CLMS.05 – Encounters Data</li> <li>LA.ENC.01 Encounter Data Policy and Procedures_LHCC</li> <li>Encounter Acceptance Reporting</li> <li>Encounter Paid Allowed Amount Examples</li> </ul>	<p><input type="checkbox"/> NA</p>
<p><b>MCE Description of Process:</b> LHCC submits complete and accurate Encounter Data at least monthly for all dates of service during the term of this Contract to LDH or FI, as directed by LDH.</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.		

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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**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> See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>LA.QI.01 2024 Quality Program Description: Pgs. 1-78, Entire Document; Pgs. 45-46, QAPIC Committee Section</li> <li>2024 LHCC QI Medicaid Work Plan: Column C and D, Work Plan Per Dept tab</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 scope of the health plan’s Quality Assessment &amp; Performance Improvement (QAPI) program is comprehensive and addresses both the quality and safety of physical health and behavioral health services and clinical care provided to Louisiana Healthcare Connections (LHCC) members. LHCC incorporates all demographic groups, care settings, and services in its quality management and improvement activities. The Quality Assessment and Performance Improvement Committee (QAPIC) is the senior management lead committee accountable directly to the Board of Directors and reports Quality Program activities, findings, recommendations, actions, and results to the Board of Directors and the Louisiana Department of Health (LDH). The QAPIC serves as the umbrella committee through which all subcommittee activities are reported and approved. Louisiana Healthcare Connections QAPIC’s structure is designed to continually promote information, reports, and improvement activity results, driven by the Quality Work Plan, throughout the organization and to providers, members, and stakeholders.</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>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>MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2</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>• 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> <hr/> <p><b>Evidence as Submitted by the MCE:</b> See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>• LA.QI.01 2024 Quality Program Description: Pgs. 48-49, Population Health &amp; Clinical Operations Committee Charter Section; Pg. 39, Performance Improvement Activities Section; Pg. 15, Scope Section, first annotation; Pgs. 19-20, Quality Program Structure Section</li> <li>• LA.UM.01 Utilization Management Program Description: Pg. 8, Implementation Section; Pg. 11, Population Health and Clinical Operations Committee Section; Pg. 11, PHCOC Scope Section; Pg. 12, PHCOC Scope Section; Pg. 28, Monitoring Over and Under-Utilization Section</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>2024 LHCC QI Medicaid Work Plan: Rows 53 &amp; 54, Work Plan Per Dept tab</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 31-33, UM Key Performance Indicators Section</li> <li>2024 Utilization Management Program Evaluation: Pg. 6, PHCO Committee Section; Pgs. 16-22, UM Key Performance Indicators Section</li> <li>PHCO Committee Meeting Minutes Q4 2024: Pg. 5, Annual Documents &amp; Policies Section</li> <li>QAPI Committee Meeting Minutes Q1 2025: Pgs. 11-13, PHCO Committee Section</li> </ul>	
<p><b>MCE Description of Process:</b> An area addressed by the Louisiana Healthcare Connections (LHCC) Quality Program is monitoring utilization patterns by performing periodic assessments of utilization data to identify potential over- and under-utilization issues or practices. The LHCC Quality Assessment and Performance Improvement Committee (QAPIC) directs subcommittees to implement improvement activities based on performance trends, members, providers, and system needs. As noted in their charter, the Population Health &amp; Clinical Operations (PHCO) subcommittee's purpose is to review and monitor the appropriateness of care and guard against over and underutilization of services provided to the Plan members. The committee meets quarterly and examines reports of the appropriateness of care trends or patterns of under or over utilization and refers identified outlier provider/provider groups to the QAPIC for performance improvement and/or corrective action. The Plan also uses prospective claims review software, post payment claims review software, and utilization reporting to monitor potentially inappropriate or duplicative services including those which may be considered fraud or abuse of the Medicaid Program.</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 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><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



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Requirement	Supporting Documentation	Score
<p>MCO Contract: 2.16.2.3.8            PAHP Contract: 2.11.1.1.4            PIHP Contract: 12.1.1.3</p>	<p>42 CFR §438.330(b)(4)            42 CFR §457.1240(b)</p> <ul style="list-style-type: none"> <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> <p><b>Evidence as Submitted by the MCE:</b>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>LA.QI.01 2024 Quality Program Description: Pg.12, Introduction Section; Pg. 23-25, Quality Program Resources: Infrastructure and Data Analytics Section; Pgs. 32-33, Medical Record Review (PQMP) Section; Pg. 38, Practice Guidelines Section</li> <li>2024 LHCC QI Medicaid Work Plan: Row 23, Work Plan Per Dept tab</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 17-18, CM Enrollment Section; Pg. 19-21, Start Smart for Your Baby Section; Pg. 21, Perinatal Substance Use Program Section; Pgs. 22-24, Post Discharge Outreach Section; Pgs. 24-26, Member Experience with Care Management Services Section; Pg. 25, CM Strengths and Accomplishments Section; Pgs. 79-81, CAHPS Section; Pg. 90, Behavioral Health Disease Management (BH DM) Clinical Measures</li> </ul>	



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Requirement	Supporting Documentation	Score
	<p>Section; Pgs. 90-91, Clinical Practice Guidelines Section</p> <ul style="list-style-type: none"> <li>• LA.CM.01 Care Management Program Description: Pgs. 1-2, Definitions Section; Pgs. 11-12, Intensive Case Management/ (High/Tier 3) Section; Pgs. 25-26, Referral Sources Section; Pgs. 39-44, Population Management Section</li> <li>• Health Risk Screening Tool LA: Entire Document</li> <li>• Health Needs Assessment LA: Entire Document</li> <li>• Pediatric Comprehensive Member Assessment LA: Pg. 1, Entire Document</li> <li>• Comprehensive Member Assessment LA: Pgs. 1-18, Entire Document</li> <li>• Chronic Conditions Assessment LA: Pgs. 1-33, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections leadership team is committed to focusing clinical, network, and operational processes towards improving the health of members including all demographic groups and those with special health care needs (SHCN). The Care Management program has mechanisms in place to identify those individuals with special health care needs. The definition and description of this population is noted in the plan’s Care Management Program Description. All members identified as SCHN are outreached and offered case management/care coordination services. The plan monitors and assesses the appropriateness of the care furnished to individuals with SHCN by evaluating care management programs and results of the CAHPS Children with Chronic Conditions survey. Measurement and analysis of the Care Management Program and the care provided to the SHCN population is documented in the annual Care Management Program Evaluation and included in the annual Quality Improvement Program Evaluation and presented to Quality Assessment and Performance Improvement Committee (QAPIC), for review and feedback.</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>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> <p style="margin-left: 20px;">a. Assessment of care between care settings; and</p> <p style="margin-left: 20px;">b. Comparison of services and supports received with those set forth in the member’s treatment/service plan, if applicable.</p> <p style="text-align: right; margin-right: 20px;">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>	<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> Louisiana Healthcare Connections does not manage the Long-Term Services and Supports (LTSS) population.</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>		
Performance Measurement		
<p>5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually:</p> <p style="margin-left: 20px;">a. Measures and reports to the State on its performance, using the standard measures required by the State;</p> <p style="margin-left: 20px;">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</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> </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>c. Performs a combination of the activities described in subelements (a) and (b).</p> <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>	<ul style="list-style-type: none"> <li>• Evidence of submission of performance measurement reports to the State</li> </ul> <p><b>Evidence as Submitted by the MCE:</b>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>• LA.QI.01 2024 Quality Program Description: Pg. 14, Scope Section; Pgs. 28-30, Performance Measurement Section; Pgs. 38-40, Performance Improvement Activities Section; Pg. 41, Regulatory Compliance and Reporting Section</li> <li>• 2024 LHCC Quality Program Evaluation: Pgs. 45-50, Quality Performance Measure and Outcomes Section; Pgs. 79-81, CAHPS Section; Pgs. 138-139, Performance Improvement Projects &amp; Performance Measures Section; Pgs. 54-67, Quality Improvement Activities Section</li> <li>• LA.QI.21 HEDIS Reporting: Pg. 1, Purpose Section; Pg. 1 Policy Section</li> <li>• 2024 LHCC QI Medicaid Work Plan: Rows 17, 19, 24, 94-98, Work Plan Per Dept tab</li> <li>• 138 LHCC 2024 A: Pgs. 1-347, Entire Document</li> <li>• 0132 LHCC Reporting Year 2024 (MY2023) Member Satisfaction Survey CAHPS: Pg. 1</li> <li>• LA.QI.12 Quality PIPs: Pgs. 1-7 Entire Document</li> <li>• LA.QI.06 Member Experience Analysis: Pgs. 1-3 Entire Document</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LA.QI.21 HEDIS Reporting: Pgs. 1-12, Entire Document</li> <li>LHCC Reporting Year 2024(MY2023): Non-HEDIS Measures All Tabs, Entire Document</li> <li>LHCC Reporting Year 2024 (MY2023) IDSS Workbook: All Tabs, Entire Document</li> <li>LHCC Reporting Year 2024 (MY2023) HEDIS Rates: Pg. 1, Entire Document</li> <li>LHCC Reporting Year 2024 (MY2023) Non-HEDIS Rates: Pg. 1, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections (LHCC) continually monitors and analyzes data to measure performance against established benchmarks and to identify and prioritize improvement opportunities. Specific interventions are developed and implemented to improve performance, and the effectiveness of each intervention is measured at specific intervals applicable to the intervention. Louisiana Healthcare Connections collects and reports performance measures data in accordance with the Quality Companion Guide published by Louisiana Department of Health (LDH). These performance measures include Healthcare Effectiveness Data and Information Set (HEDIS) rates, Agency for Healthcare Research and Quality Review (AHRQ) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, Process Improvement Projects, and/or other measures as determined by 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>		
Performance Improvement Projects		
<p>6. The QAPI program includes performance improvement projects (PIPs).</p> <p style="margin-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> <li>QAPI program evaluation</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>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>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>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>LA.QI.12 Quality PIPs: Pgs. 1-2, Procedure Section, number 1; Pg. 1, Policy Section, first paragraph; Pg. 3, Ten-Step Methodology Section, step 1</li> <li>LA.QI.01 2024 Quality Program Description: Pgs. 38-40, Performance Improvement Activities Section; Pgs. 77-78, Appendix B, Performance Measures &amp; Performance Improvement Projects Section</li> <li>2024 LHCC QI Medicaid Work Plan: Rows 94-98, Work Plan Per Dept tab</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 54-67, Quality Improvement Activities Section; Pg. 138, Performance Improvement Projects &amp; Performance Measures Section</li> <li>138 LHCC 2024 A: Pgs. 1-347, Entire Document</li> <li>Cervical Cancer Screening LA2024 PIP-Submission Form: Pgs. 1-61, Entire Document</li> <li>Congenital Syphilis LA2024 PIP Submission Form: Pgs. 1-52, Entire Document</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• Fluoride Varnish LA2024_PIP-Submission Form: Pgs. 1-66, Entire Document</li> <li>• Behavioral Health Transitions in Care LA2024 PIP-Submission Form: Pgs. 1-89, Entire Document</li> <li>• Screening for HIV Infection LA2024 PIP-Submission Form: Pgs. 1-83, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections establishes and implements ongoing comprehensive quality assessment and performance improvement projects (PIPs) that meet the requirements of the State as detailed in the contracted scope of services pursuant to 42 C.F.R. § 438.330 and use the ten-step methodology recommended by Department of Health and Human Services Centers for Medicare and Medicaid Services EQR Protocol 7 Implementation of Performance Improvement Projects or comparable methodology to implement quality improvement initiatives and include at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.</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>Measurement of performance using objective quality indicators.</li> <li>Implementation of interventions to achieve improvement in the access to and quality of care.</li> <li>Evaluation of the effectiveness of the interventions based on the performance measures required by the State.</li> <li>Planning and initiation of activities for increasing or sustaining improvement.</li> </ol> <p style="text-align: right;">42 CFR §438.330(d)(2)</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>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>• LA.QI.01 2024 Quality Program Description: Pgs. 38-40, Performance Improvement Activities Section; Pgs. 77-78, Appendix B, Performance</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<p style="text-align: right;">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>Measures &amp; Performance Improvement Projects Section</p> <ul style="list-style-type: none"> <li>2024 LHCC QI Medicaid Work Plan: Rows 94-98, Work Plan Per Dept tab</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 55-56, PIP #1- Screening for HIV Infection Section; Pgs. 56-58 PIP #2-Cervical Cancer Screening Section; Pgs. 59-61, PIP #3-Fluoride Varnish Application by PCPs Section; Pgs. 61-64, PIP #4-BH Transitions of Care Section; Pgs. 64-67, PIP #5-Syphilis screening during pregnancy Section; Pgs. 138-139, Performance Improvement Projects &amp; Performance Measures Section</li> <li>LA.QI.12 Quality PIPs: Pg. 1, Policy Section, first bullet point; Pg. 2, Procedure Section, number 3; Pgs. 5-6, Ten Step Methodology Section, steps 7 - 10</li> <li>138 LHCC 2024 A: Pgs. 1-347, Entire Document</li> <li>Cervical Cancer Screening LA2024 PIP-Submission Form: Pgs. 1-61, Entire Document</li> <li>Congenital Syphilis LA2024 PIP Submission Form: Pgs. 1-52, Entire Document</li> <li>Fluoride Varnish LA2024_PIP-Submission Form: Pgs. 1-66, Entire Document</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>Behavioral Health Transitions in Care LA2024 PIP-Submission Form: Pgs. 1-89, Entire Document</li> <li>Screening for HIV Infection LA2024 PIP-Submission Form: Pgs. 1-83, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections monitors and analyzes data to measure performance against established benchmarks and to identify and prioritize improvement opportunities. Specific interventions are developed and implemented to improve performance, and the effectiveness of each intervention is measured at specific intervals applicable to the intervention. Louisiana Healthcare Connections collects and reports performance measures data in accordance with the Quality Companion Guide published by Louisiana Department of Health (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>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 PIHP 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> See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>LA.QI.12 Quality PIPs: Pg. 1, Policy Section, second bullet point; Pgs. 1-2, Procedure Section</li> <li>138 LHCC 2024 A: Pgs. 1-347, Entire Document</li> <li>Cervical Cancer Screening LA2024 PIP-Submission Form: Pgs. 1-61, Entire Document</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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	<ul style="list-style-type: none"> <li>Congenital Syphilis LA2024 PIP Submission Form: Pgs. 1-52, Entire Document</li> <li>Fluoride Varnish LA2024_PIP-Submission Form: Pgs. 1-66, Entire Document</li> <li>Behavioral Health Transitions in Care LA2024 PIP-Submission Form: Pgs. 1-89, Entire Document</li> <li>Screening for HIV Infection LA2024 PIP-Submission Form: Pgs. 1-83, Entire Document</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 138-139, Performance Improvement Projects &amp; Performance Measures Section; Pgs. 55-56, PIP #1- Screening for HIV Infection Section; Pgs. 56-58, PIP #2-Cervical Cancer Screening Section; Pgs. 59-61, PIP #3-Fluoride Varnish Application by PCPs Section; Pgs. 61-64, PIP #4-BH Transitions of Care Section; Pgs. 64-67, PIP #5-Syphilis screening during pregnancy Section</li> </ul>	
<p><b>MCE Description of Process:</b> Louisiana Healthcare Connections monitors and analyzes data to measure performance against established benchmarks and to identify and prioritize improvement opportunities. Specific interventions are developed and implemented to improve performance, and the effectiveness of each intervention is measured at specific intervals applicable to the intervention. Louisiana Healthcare Connections collects and reports performance measures data in accordance with the Quality Companion Guide published by the Louisiana Department of Health (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>		



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Requirement	Supporting Documentation	Score
<b>Critical Incidents</b>		
<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="text-align: right; margin-right: 20px;">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>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>LA.QI.34 Adverse Incidents: Pgs. 1-6, Entire Document</li> <li>LA.QI.17 Potential Quality of Care Incidents, Pgs. 1-9, Entire Document</li> <li>LA.QI.01 2024 Quality Program Description: Pgs. 31-32, Promoting Member Safety and Quality of Care Section</li> <li>2024 LHCC QI Medicaid Work Plan: Row 76, Work Plan Per Dept tab</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 68-70, Patient Safety Section, Pg. 126, Recommendations for 2025 QI Program Section</li> </ul>	<input type="checkbox"/> Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> NA



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	<ul style="list-style-type: none"> <li>QAPI Committee Meeting Minutes Q2 2024: Pg. 25, Grievance &amp; Appeals Committee Section</li> <li>QAPI Committee Meeting Minutes Q3 2024: Pg. 26, Grievance &amp; Appeals Committee Section</li> <li>QAPI Committee Meeting Minutes Q4 2024: Pgs. 6-7, Grievance &amp; Appeals Committee Section</li> <li>QAPI Committee Meeting Minutes Q1 2025: Pg 10, Grievance &amp; Appeals Committee Section</li> <li>QOC CAP Template: Pg. 1, Entire Document</li> <li>QOC Letter to Facility Template: Pg. 1, Entire Document</li> <li>2024 Quality of Care Tracking Log, Tab 1, Entire Document</li> <li>2024 Adverse Incidents Tracking Log, Tab 1, Entire Document</li> </ul>	
<p><b>MCE Description of Process:</b> The Louisiana Healthcare Connections (LHCC) Quality Assessment and Performance Improvement (QAPI) Program actively participates in Louisiana state-led initiatives to prevent, detect, and remediate critical incidents involving members. This participation aligns with federal requirements under 42 CFR §441.302(h) and §441.730(a), ensuring the health and welfare of beneficiaries receiving services. LHCC collaborates with the state through regular reporting, root cause analysis, and corrective action planning related to critical incidents. These activities are incorporated into QAPI work plans, which are reviewed and updated regularly to reflect state guidance and promote continuous improvement in safeguarding member well-being.</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>		



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<b>QAPI Program Reviews, Analysis, and Evaluation</b>		
<p>10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes:</p> <p style="margin-left: 20px;">a. The performance on the measures on which it is required to report.</p> <p style="margin-left: 20px;">b. The outcomes and trended results of each PIP.</p> <p style="margin-left: 20px;">c. The results of any efforts to support community integration for members using LTSS.</p> <p>MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.</i></p> <p style="margin-left: 40px;">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>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>2024 LHCC Quality Program Evaluation: Pgs. 14-38, Quality Program Effectiveness Section; Pgs. 45-50, Quality Performance Measures and Outcomes Section; Pgs. 54-67, Quality Improvement Activities Section</li> <li>QAPI Committee Meeting Minutes Q1 2025: Pgs. 2-3, Annual QAPI Trilogy Documents Section; Pgs. 10-11, Performance Improvement Committee Section</li> <li>QAPI Committee Meeting Minutes Q1 2024: Pg. 2, Review and Approval of Annual Documents Section</li> <li>2024 LHCC QI Medicaid Work Plan: Entire Document, all tabs</li> <li>LA.QI.01 2024 Quality Program Description: Pgs. 18-19, Authority Section; Pgs. 27-28, Quality Program Evaluation Section</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> Once a year, Louisiana Healthcare Connections (LHCC) Quality Improvement Department conducts a formal evaluation of the Quality Assessment and Performance Improvement (QAPI) Program. This evaluation includes performance on required quality measures and the outcomes and trended results of each Performance Improvement Project (PIP). The results are presented to the QAPIC</p>		



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committee, and the evaluation is also reviewed annually by the Board of Directors, ensuring appropriate oversight and governance. LHCC does not manage a Long-Term Services and Supports (LTSS) population; therefore, community integration efforts for this population are not applicable.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
<p>11. QAPI Committee Requirements:</p> <p>MCO:</p> <p>a. <i>The MCO forms a QAPI Committee that at a minimum includes:</i></p> <p>i. <i>The MCO's Medical Director who must serve as either the chairman or co-chairman;</i></p> <p>ii. <i>The MCO's Behavioral Health Director;</i></p> <p>iii. <i>Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;</i></p> <p>iv. <i>Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and</i></p> <p>v. <i>An Enrollee representative(s) and/or advocate(s).</i></p> <p>PAHP:</p> <p>a. <i>The PAHP shall form a QAPI Committee that shall, at a minimum include:</i></p> <p>i. <i>The Dental Director who must serve as either the chairman or co-chairman;</i></p> <p>ii. <i>Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and</i></p>	<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>• See bookmarks and annotations in the following documents:</li> <li>• QAPI Committee Meeting Minutes Q2 2024: Pg. 1, Attendance Record Section</li> <li>• QAPI Committee Meeting Minutes Q3 2024: Pg. 2, Attendance Record Section</li> <li>• QAPI Committee Meeting Minutes Q4 2024: Pg. 1, Attendance Record Section</li> <li>• QAPI Committee Meeting Minutes Q1 2025: Pg. 1, Attendance Record Section</li> <li>• LA.QI.01 2024 Quality Program Description: Pgs. 18-19, Authority Section; Pgs. 19-20, Quality Program Structure Section; Pg. 23, Inter/Intradepartmental QAPI Program Resources Section; Pgs. 45-46, QAPIC Committee Section</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>iii. <i>The PAHP shall include an enrollee advocate representative on the QAPI Committee.</i></p> <p>PIHP:</p> <p>a. <i>The PIHP shall form a QAPI committee that shall, at a minimum include:</i></p> <p style="margin-left: 20px;">i. <i>The PIHP’s Medical Director, who must serve as the chair or co-chair and</i></p> <p style="margin-left: 20px;">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></p> <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 Quality Assessment and Performance Improvement Committee (QAPIC) is Louisiana Healthcare Connections (Plan) senior leadership committee, accountable to the Board of Directors (BOD), that reviews and monitors all clinical quality and service functions of the Plan and provides oversight of all sub-Committees- except for the Compliance Committee which reports directly to the BOD. The Plan’s Chief Medical Officer is the Senior Executive for Quality Improvement responsible for the implementation of the QAPI Program and chairs the QAPIC committee. Louisiana Healthcare Connections senior management staff, Behavioral Medical Directors, medical and behavioral health clinical staff, network practitioners, and member advocates are involved in the implementation, monitoring, and directing of the relative aspects of the quality improvement program through the QAPIC.</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>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>            See bookmarks and annotations in the following documents:</p> <p>a. 2024 LHCC QI Medicaid Work Plan: Entire Document; Row 5, Work Plan Per Dept Tab</p> <p style="margin-left: 20px;">i. LA.QI.01 2024 Quality Program            Description: Pgs. 19-20, Quality Program Structure Section; Pgs. 45-46, QAPIC Committee Section</p> <p style="margin-left: 20px;">ii. LA.QI.01 2024 Quality Program            Description: Pgs. 19-20, Quality Program Structure Section; Pg. 23, Inter/Intradepartmental QAPI Program Resources Section; Pgs. 38-40, Performance</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>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>	<p>Improvement Activities Section; Pgs. 45-46, QAPIC Committee Section; Pgs. 44-65, Committee Charters Section</p> <p>QAPI Committee Meeting Minutes Q2 2024: Pg. 1, Attendance Record Section</p> <p>QAPI Committee Meeting Minutes Q3 2024: Pg. 2, Attendance Record Section</p> <p>QAPI Committee Meeting Minutes Q4 2024: Pg. 1, Attendance Record Section</p> <p>QAPI Committee Meeting Minutes Q1 2025: Pg. 1, Attendance Record Section</p> <p>iii. 2024 LHCC Quality Program Evaluation: Pgs. 1-140, Entire Document; Pgs. 125-128, Recommendations for 2025 QI Program Section</p> <p>QAPI Committee Meeting Minutes Q1 2025: Pgs. 2-3. Annual QAPI Trilogy Documents Section</p> <p>iv. LA.QI.01 2024 Quality Program Description: Pgs. 19-20, Quality Program Structure Section; Pgs. 44-65, Committee Charters Section</p> <p>v. LA.QI.01 2024 Quality Program Description: Pg. 40, Performance Improvement Activities Section</p> <p>vi. LA.QI.22 Provider Profiling: Pgs. 1-3, Entire Document</p> <p>LA.QI.01 2024 Quality Program Description: Pgs. 37-38, Provider Supports</p>	



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<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>Section; Pgs. 66-68, Appendix B, Pay for Performance Overview Section</li> <li>vii. Performance Improvement Committee Meeting Minutes Q3 2024: Pg. 3, Provider Quality Section; Pgs. 4-5, Provider Relations Section</li> <li>Performance Improvement Committee Meeting Minutes Q4 2024: Pg. 4, Provider Quality Section</li> <li>QAPI Committee Meeting Minutes Q1 2025: Pg. 16, Physician Advisory Committee Section; Pg. 16, Value Based Payment Section; Pgs. 3-4, Practice Management Advisory Committee Section; Pgs. 15-16, Credentialing Committee Section</li> <li>QAPI Committee Meeting Minutes Q1 2024: Pg. 21, Credentialing Committee Section; Pgs. 22-23, Practice Management Advisory Committee Section</li> <li>QAPI Committee Meeting Minutes Q3 2024: Pg. 50, Practice Management Advisory Committee Section; Pgs. 50-53, Value Based Payment Section; Pg. 49, Credentialing Committee Section</li> <li>2024 LHCC Quality Program Evaluation: Pgs. 131-133, Appendix A, Pay for Performance Section</li> <li>viii. LA.QI.01 2024 Quality Program Description: Pg. 39, Performance</li> </ul>	



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<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>Improvement Activities Section; Pgs. 48-49, Population Health &amp; Clinical Operations Committee Charter Section</p> <p>QAPI Committee Meeting Minutes Q2 2024: Pgs. 37-42, PHCO Committee Section</p> <p>QAPI Committee Meeting Minutes Q3 2024: Pgs. 38-39, PHCO Committee Section</p> <p>QAPI Committee Meeting Minutes Q4 2024: Pgs. 9-11, PHCO Committee Section</p> <p>QAPI Committee Meeting Minutes Q1 2025: Pgs. 11-13, PHCO Committee Section</p> <p>ix. LA.QI.01 2024 Quality Program Description: Pgs. 19-20, Quality Program Structure Section</p> <p>QAPI Committee Meeting Minutes Q2 2024: Pgs. 1-49, Entire Document</p> <p>QAPI Committee Meeting Minutes Q3 2024: Pgs. 1-54, Entire Document</p> <p>QAPI Committee Meeting Minutes Q4 2024: Pgs. 1-14, Entire Document</p> <p>QAPI Committee Meeting Minutes Q1 2025: Pgs. 1-17, Entire Document</p> <p>PQ119 Record of Submission 2024: Pgs. 1-4, Entire Document</p> <p>x. 136 LHCC 2024: Pgs. 1-3, Entire Document</p> <p>xi. LA.QI.01 2024 Quality Program Description: Pgs. 18, Authority Section, second annotation</p>	



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	xii. LA.QI.01 2024 Quality Program Description: Pgs. 19-20, Quality Program Structure Section; Pg. 23, Inter/Intradepartmental QAPI Program Resources Section; Pgs. 38-40, Performance Improvement Activities Section; Pgs. 45-46, QAPIC Committee Section; Pgs. 44-65, Committee Charters Section  xiii. 2024 Provider Manual Updates: Pgs. 1-2, Entire Document	
<p><b>MCE Description of Process:</b> The Quality Assessment &amp; Performance Improvement Committee (QAPIC) is the senior management lead committee and is accountable directly to the Board of Directors. The QAPIC meets at least quarterly and is responsible for the oversight of the quality management program, policies, and procedures. The QAPIC reviews and analyzes Quality Improvement (QI) project results driven by the Quality work plan, identifies needed actions, recommends policy decisions, and follows up on open issues. The QAPIC includes practitioners with various specialties who participate in the design and/or review of the QI Program or select program components. Participants also include key staff from various operational departments including Quality, Population Health &amp; Clinical Operations, Health Equity, Vendor Management, Operations, Utilization Management, Provider Network/Engagement, Credentialing, Pharmacy, Medical Affairs, Finance, and Compliance Department. The QAPIC directs subcommittees to implement improvement activities based on performance trends, member, provider, and system needs. These committees assist with monitoring and supporting the Quality Program. All committees maintain written minutes and submit QAPI meeting minutes to the Louisiana Department of Health.</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>		
13. QAPI Plan Requirements: MCO:	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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<ul style="list-style-type: none"> <li>a. <i>The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.</i></li> <li>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></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 and metrics to evaluate the impact and effectiveness of the QAPI Program;</i></li> <li>iii. <i>Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;</i></li> <li>iv. <i>Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;</i></li> <li>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></li> <li>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></li> </ul> </li> </ul>	<p><b>Evidence as Submitted by the MCE:</b>            See bookmarks and annotations in the following documents:</p> <ul style="list-style-type: none"> <li>a. LA.QI.01 2024 Quality Program Description: Pgs. 18-19, Authority Section</li> <li>b. 136 LHCC 2024: Pgs. 1-3, Entire Document</li> <li>c.               <ul style="list-style-type: none"> <li>i. LA.QI.01 2024 Quality Program Description: Pgs. 19-20, Quality Program Structure Section; Pg. 26 Quality Program Description Section 2024 LHCC QI Medicaid Work Plan: Entire Document, all tabs</li> <li>ii. LA.QI.01 2024 Quality Program Description: Pgs. 27-28, Quality Program Evaluation Section</li> <li>iii. LA.QI.01 2024 Quality Program Description: Pgs. 20-23, Quality Department Staffing Section</li> <li>iv. LA.QI.01 2024 Quality Program Description: Pg. 15, Scope Section, second annotation; Pgs. 45-46 QAPIC Committee Section; Pgs. 52-53, Physician Advisory Committee Section; Pgs. 62-65, Member Advisory Council Section</li> <li>v. LA.QI.01 2024 Quality Program Description: Pg. 1, Policy and Procedure Section</li> </ul> </li> </ul>	



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<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>	<ul style="list-style-type: none"> <li>vi. LA.QI.01 2024 Quality Program            Description: Pgs. 28-30 Performance Measurement Section; Pg. 23-25, Quality Program Resources: Infrastructure and Data Analytics Section; Pg. 38, Practice Guidelines Section</li> </ul>	



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<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> </ul>		



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<p>c. <i>The QAPI work plan at a minimum shall:</i>  <i>Include objectives for the Contract year, inclusive of associated action steps and timelines.</i></p> <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>		



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<p><b>MCE Description of Process:</b> The written Quality Assessment and Performance Improvement (QAPI) Plan, developed with oversight by the Board of Directors, outlines Louisiana Healthcare Connections (LHCC) structure and processes to monitor and improve the quality and safety of clinical care, and the quality of services provided to members. The written plan includes the following at minimum: the scope and structure of the Quality Program, including the behavioral health aspects of the program; the specific role, structure, function, and responsibilities of the QAPIC and subcommittees/work groups, including meeting frequency and accountability to the governing body; a description of dedicated Quality Program staff and resources, including involvement of a designated physician and behavioral health care practitioner. No less than annually, ideally during the first quarter of each calendar year, the designated Quality Department staff prepares, reviews, and revises (as needed) the Quality Program Description. LHCC also annually evaluates the results of QAPI activities and the impact on improving the quality of physical health and behavioral health service delivery with appropriate input from Enrollees and providers. This evaluation includes results of performance measures that demonstrate provider adherence to clinical practice guidelines and/or improvement in patient outcomes for both medical and behavioral health populations. The QAPI Plan is reviewed and approved by the QAPIC and Board of Directors on an annual basis. Substantial changes to its QAPI plan are also submitted to the Louisiana Department of Health (LDH) for review prior to implementation and annually as required by state contract.</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 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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.02 Grievance Process: page 1: section Definitions (Grievance)</li> <li>• LA.QI.11.02 Grievance Process: page 1: section Definitions (Adverse Action)</li> <li>• LHCC Member Handbook: page 66: section Grievances.</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> Member grievances are submitted to LHCC by phone, fax, email or regular mail. Upon receipt a Grievance and Appeals Coordinator (GAC) will review the document (triage) for its content and route the grievance to the appropriate work queue for entry into the Grievance management workflow. The policy and procedure as well as the Member Handbook submitted are evidence that validates LHCC's operational definition as to what constitutes a grievance are aligned with the MCO Contract.</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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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<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 style="text-align: right; padding-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>	<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 Grievances File Review</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 3, section Authority to File</li> <li>LHCC Member Handbook: page 66, section How to File a Grievance</li> <li>Member consent form template- Element 2</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 an effort to advocate on behalf of a member, a process has been developed to allow a representative to submit a grievance to the health plan (given that they have the member’s written permission to represent them). As evidence of the work process to accommodate that deliverable, in addition to evidence of communicating that to the member as an option, when filing a grievance LHCC submits the Member Handbook and the Policy and Procedure governing the member grievance process. LHCC has also submitted a copy of the member consent form that can be found in the Member Handbook as well as LHCC’s website.</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 member may file a grievance either orally or in writing.</p> <p style="text-align: right; padding-right: 20px;">42 CFR §438.228            42 CFR §438.402(c)(3)(i)            42 CFR §457.1260(b)(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 system demonstration</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
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	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 3, section Procedures for Filing</li> <li>LHCC Member Handbook: page 66, section How to File a Grievance.</li> </ul>	
<b>MCE Description of Process:</b> Members may call customer service to file a grievance orally or submit a grievance in writing by sending in writing by mail, fax or email.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Handling of Grievances		
4. The MCE acknowledges receipt of each grievance. MCO and PAHP: 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> PIHP: 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>  42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d)	<b>HSAG Required Evidence:</b> <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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
	<b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 7, section 5 a.</li> <li>Grievance Acknowledgement Template- Element 4</li> <li>Tracking and reporting mechanisms- Element 4</li> </ul>	



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Requirement	Supporting Documentation	Score
MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1		
<p><b>MCE Description of Process:</b> In step 1 for managing a member grievance the Grievance and Appeals Coordinator (GAC) will attempt a telephonic outreach to the member to acknowledge their grievance and clarify the LHCC fully understands the circumstance leading to the complaint. That conversation (or message if the GAC can't reach the member by phone) is followed-up with a written acknowledgement of LHCC's receipt of the grievance. As evidence to support that process step LHCC submits the Policy and Procedure in addition to a copy of an acknowledgement template and the tracking log LHCC uses to ensure compliance with this contractual obligation. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon request</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>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</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>• LA.QI.11.02 Grievance Process: page 4, section The Plan shall refer all Members who are dissatisfied with the Plan or its activities to the Plan's Grievance system</li> <li>• Organizational chart of grievance staff member-Element 5</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
42 CFR §438.406(b)(2) 42 CFR §457.1260(d)  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		
<b>MCE Description of Process:</b> The Grievance and Appeals Coordinator who is working on the grievance is trained to route the grievance to whatever department can best provide a resolution to the member’s satisfaction. As such, a grievance that has a clinical component could be routed to a Case Manager, a Quality Improvement Coordinator (Behavioral Health & Physical Health clinicians) or any other department who can expertly address the clinical element in the complaint. As evidence of compliance with this element LHCC submits the Policy and Procedure outlining the work process aligned with the contract requirement.		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
Timely Resolution and Notification of Grievances		
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.  MCO and PAHP Standard Grievances 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>  PIHP Standard Grievances 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>	<b>HSAG Required Evidence:</b> <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> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LA.QI.11.02 Grievance Process: page 6, section Standard Disposition of Grievances</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(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>	<ul style="list-style-type: none"> <li>Grievance resolution notice template or oral notification script- Element 6</li> <li>Tracking and reporting mechanisms- Element 6</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC uses the Grievance Tracking Log to ensure compliance by way of managerial oversight with the 90 day resolution timeline. The tracking log is monitored weekly by LHCC management and reported to the state monthly to demonstrate compliance with the standard. As evidence of that work process LHCC is providing its Policy and Procedure governing member grievances. Further evidence of compliance will be demonstrated by way of the case file audits. As requested, please find a copy of the grievance resolution letter. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon 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>7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if:</p> <p style="padding-left: 20px;">a. The member requests the extension; or</p> <p style="padding-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;">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 N/A</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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 6, section Extension of Timeframes (2.15.3.5)</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><b>MCE Description of Process:</b> LHCC has not extended a grievance resolution beyond the 90-day contractual obligation since the Plan’s inception according to the tracking logs. None-the-less we do have a provision built into our Grievance Process should that situation arise that includes reaching out to LDH for their consent and then communicating that delay to the member. As for evidence of LHCC’s work process regarding file extension we submit our Policy and Procedure.</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. 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: 20px;">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 N/A</li> <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>LA.QI.11.02 Grievance Process: page 6, section Extension of Timeframes (2.15.3.5)</li> <li>Grievance extension template letter- Element 8</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> LHCC has not extended a grievance resolution beyond the 90-day contractual obligation since the Plan’s inception according to the tracking logs. None-the-less we do have a provision built into our Grievance Process should that situation arise that includes reaching out to LDH for their consent and then communicating that delay to the member first telephonically and following the call up with a letter. As for evidence of LHCC’s work process regarding file extension we submit our Policy and Procedure in addition to the letter template.</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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Standard XIII—Grievance and Appeal Systems		
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>• LA.QI.11.03 Appeals Process: page 1, Appeal and Appeal Procedure definitions</li> <li>• LHCC Member Handbook: page 61, section Appeals.</li> <li>• LHCC Provider Handbook: page 148, section Appeals</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> LHCC defines an Appeal in its Policy and Procedure as” A formal process whereby a member has the right to contest an adverse determination/action rendered by the Plan, which results in the denial, reduction, suspension, termination, or delay of health care benefits/services.” As evidence of this Plan interpretation of an appeal LHCC submits the Policy and Procedure governing appeals as well as the Member Handbook where in easy to understand language LHCC shares the definition of an appeal with the member.</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>• LA.QI.11.03 Appeals Process: page 7, section C. 1. a</li> </ul>	<p><input type="checkbox"/> Met</p> <p><input type="checkbox"/> Not Met</p> <p><input checked="" type="checkbox"/> NA</p>



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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LHCC Member Handbook: page 63, section State Fair Hearing for Appeals</li> <li>LHCC Provider Handbook: page 149, section State Fair Hearing Process</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC has only one level of a formal appeal for members. The work process is detailed in the policy and Procedure submitted as evidence for this contractual element. The section in the Member Handbook has also been submitted where the one level appeal process is presented in easy to understand language for the member.</p>		
<p><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.</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>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>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;">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>LA.QI.11.03 Appeals Process: page 3, section 14</li> <li>LA.QI.11.03 Appeals Process: page 4, section Appeal Process d (3)</li> <li>LHCC Member Handbook: page 63, section Fast Appeal Decisions.</li> <li>LHCC Provider Handbook: page 149, section Expedited Appeals</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><b>MCE Description of Process:</b> All request for a formal appeal whether standard or expedited are triaged by a Grievance and Appeals Coordinator (GAC). The GAC will review and note that a request to expedite the appeal has been submitted to the Plan. In that instance, an email is forwarded to the Clinical Appeals Coordinator (CAC) triaging and assigning appeals reviews. The GAC will also make a note of the request to expedite the request in the record management system – TruCare. The CAC along with a medical advisor (MD) will review the appeal to determine if it meets the criteria for managing the appeal expeditiously (complete assessment and determination within 72 hours of receipt) and initiate the appropriate case review process. Evidence of the work process can be found in the Policy and Procedure and member communication in the Member Handbook submitted as evidence of compliance with this contractual obligation.</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. 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; margin-right: 100px;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 4, section 1 b</li> <li>• Tracking mechanism_Element 12</li> <li>• LHCC Member Handbook: page 61, section Appeals.</li> <li>• ABD Notice Template</li> <li>• LHCC Provider Handbook: page 148, section Appeals</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> Prior to launching the case review appeal process, the Grievance and Appeals Coordinator (GAC) will ensure the denied appeal meets the 60-day window of opportunity for filing an appeal. In the event the timeline for filing has expired, the GAC will</p>		



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Requirement	Supporting Documentation	Score
<p>inform the member and the member’s representative that the request for an appeal will be denied since the window of opportunity has expired. Evidence to support this work process can be found in the Policy and Procedure, the Member Handbook (where we callout the 60 day window), the Provider Manual (where we callout the 60 day window), the letter template and the appeals tracking log where we note the appeal as “invalid”. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon 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>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; padding-right: 20px;">42 CFR §438.228            42 CFR §438.402(c)(1)(ii)            42 CFR §438.402(c)(3)(ii)            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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.03 Appeals Process: page 4, section 1 c. 2-4.</li> <li>LHCC Member Handbook: page 62, section Who May File and Appeal.</li> <li>Member Consent form template- Element 13</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 appeals, whether delivered orally or in writing, are processed upon receipt by the Grievance and Appeals Coordinator (GAC) and entered into the appeals work queue and work process. In an instance when a member representative submits the appeal request, the GAC will also ensure LHCC is in receipt of the member’s consent. In an instance when the consent is missing in the submission the GAC CAC will contact the representative (typically the provider) and inform-them the appeal is considered invalid due to not receiving-the member consent form so that work can begin on processing their appeal request. LHCC has submitted evidence of compliance of this element by way of the Member Handbook where the reader can find the process for filing an appeal in easy to understand language, the Policy and Procedure governing member appeals as well as a copy of the member consent template.</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.		
Handling of Appeals		
<p>14. If the MCE denies a request for expedited resolution of an appeal, it:</p> <ul 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:               <ul 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> </ul> </li> </ul> <p style="text-align: right; margin-right: 50px;">           42 CFR §438.228            42 CFR §438.408(b)(2)            42 CFR §438.408(c)(2)            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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 6, section 3 b 2</li> <li>• LA.QI.11.03 Appeals Process: page 6, section 3 e</li> <li>• Denied expedited resolution template_Element 14</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> When a request for an expedited appeal has been, the Clinical Appeals Coordinator (CAC) will make immediate telephonic outreach to the member and the member’s representative regarding the decision to process the request as a standard appeal. Following the telephonic outreach the CAC will compose and mail the member and representative a letter informing the member that the request for handling the appeal expeditiously has been denied and that the appeal will be managed as a standard submission with a 30</p>		



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turnaround time. As evidence of compliance with this standard LHCC is submitting the Policy and Procedure governing appeals as well as a copy of the letter template LHCC uses for member communication.		
<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 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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.03 Appeals Process: page 4, section 1 f.</li> <li>Tracking mechanisms_Element 15</li> <li>Appeal acknowledgement template</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC’s Clinical Appeals Coordinators compose and mail acknowledgements following their contact or attempt(s) to contact the member and their representative by telephone. The letter must be completed within the five-business day contractual requirement and oversight vis-à-vis the tracking log is reviewed weekly by management for compliance. As evidence of compliance LHCC is submitting the Policy and Procedure governing appeal’s processes, the tracking log and the appeal acknowledgement letter template. Due to our</p>		



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tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log 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.		
<p>16. The MCE ensures that the individuals who made decisions on appeals 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 style="margin-left: 20px;">i. An appeal of a denial that is based on lack of medical necessity.</p> <p style="margin-left: 20px;">ii. An appeal 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 without regard to whether such information was submitted or considered in the initial ABD.</p> <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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.03 Appeals Process: page 4, section 1 h</li> <li>LA.QI.11.03 Appeals Process: page 2, section 6</li> <li>Organizational chart_ Element 16</li> <li>Medical Director Organization Chart</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> LHCC’s appeals reviewers are all clinically licensed – either Registered Nurses, Licensed Mental Health Professionals, Licensed Psychologists, or Medical Doctors (MD). Determinations to uphold or overturn denials are made by Medical Doctors or Licensed Psychologists and in instances when certification and/or license of the requestor differs from those employed by LHCC, the Clinical Appeals Coordinators will reach out to contractors such as American Medical Reviewers (AMR) for consult on the merits of the request for prior authorization and forward those recommendations to LHCC MD’s for final determination. In the review all of the information/evidence submitted by the requestor is reviewed to determine if medical necessity has been demonstrated. As evidence of compliance LHCC is submitting the Policy and Procedure governing appeals in addition to the appeal’s team organizational chart with each team member’s credentials.</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. 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>• LA.QI.11.03 Appeals Process: page 4, section 1 c (2).</li> <li>• LHCC Member Handbook: page 62, section How to File an Appeal.</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> LHCC’s Policy and Procedure allows for members and representatives to submit a request for an appeal of an adverse decision orally. LHCC submitted evidence of the work process by way of its Policy and Procedures governing appeals as well as the section in the Member Handbook that speaks to How to File an Appeal in easy-to-read language.</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>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 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>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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 3, section A 7 and 8.</li> <li>• ABD Notice Template</li> <li>• Appeal acknowledgment template</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> LHCC functions as a “member advocate” as it relates to scrutinizing all of the submitted documentation to identify any information that provides evidence of medical necessity for the prior authorization request. As such members are made aware of the denial rationale and what evidence would be necessary to overturn the denial determination; all this in addition to the timeline associated with the investigation and final determination. As evidence of compliance with this contractual obligation LHCC presents the Policy and Procedure governing appeals and acknowledgement letter templates used to communicate the appeals 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>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</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> </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>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 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>	<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>LA.QI.11.03 Appeals Process: page 4, section 1 g.</li> <li>ABD Notice Template</li> <li>Appeal resolution notice template</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC’s appeal’s work process includes a process for ensuring the member and/or their representative is provided copies of all of the information used in making its decision to uphold or overturn the denial free of charge. As evidence of compliance with this contractual obligation LHCC presents the Policy and Procedure governing appeals and letter templates used to communicate the appeals process.</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.		
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>LA.QI.11.03 Appeals Process: page 5, section 2. d. (2)</li> <li>Tracking mechanisms_Element 20</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC’s management oversight is focused on timely, complete and accurate accounting for all member appeals. Management uses a tracking log to at-a-glance ensure appeals are resolved timely and in instances when the member’s health warrants a quicker decision than the 30-day standard, the Clinical Appeals Coordinators work with the Medical Directors to process a case expeditiously. Evidence of that work process can be found in LHCC’s Policy and Procedure, and timely investigation and determination can be found in the appeals tracking log. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon request.</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. 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;">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>LA.QI.11.03 Appeals Process: page 6, section 3. f. (1)</li> <li>Tracking and reporting mechanisms_Element 21</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 requests for a formal appeal whether standard or expedited are triaged by a Grievance and Appeals Coordinator (GAC). The GAC will review and note that a request to expedite the appeal has been submitted to the Plan. In that instance, an email is forwarded to the Clinical Appeals Coordinator (CAC) triaging and assigning appeals reviews. The GAC will also make a note of the request to expedite the request in the record management system – TruCare. The CAC along with a medical advisor (MD) will review the appeal to determine if it meets the criteria for managing the appeal expeditiously (complete assessment and determination within 72 hours of receipt) and initiate the appropriate case review process. LHCC’s management oversight is focused on timely, complete and accurate accounting for all member appeals. Management uses a tracking log to at-a-glance ensure appeals are resolved timely. As such, LHCC ensures expedited appeals are resolved within the 72 hour timeline. By following Evidence of that work process can be found in LHCC’s Policy and Procedure and timely investigation and determination can be found in the appeals tracking log. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon 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>		



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<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 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: 100px;">42 CFR §438.228            42 CFR §438.408(c)(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>	<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 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>LA.QI.11.03 Appeals Process: page 6, section 3. g 1</li> <li>LA.QI.11.03 Appeals Process: page 6, section 3. g 3</li> <li>LA.QI.11.03 Appeals Process: page 5, section 2. e</li> <li>Tracking and reporting mechanisms_Element 22</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> Although LHCC has not requested an extension of an expedited appeal since its inception (according to the tracking logs), there is a work process should the need arise. Should that situation arise the Clinical Appeals Coordinator (CAC) will reach out to LDH for their consent and then communicate that delay to the member. Evidence of the work process can be found in the Policy and Procedure governing member appeals along with a copy of the tracking log. Due to our tracking mechanism being a living document, a sample of our tracking log for the review period has been provided; however, we are happy to provide the entire 2024 log upon 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>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><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> </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>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 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>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>LA.QI.11.03 Appeals Process: page 5, section 2. e bullet 2.</li> <li>Appeal extension template letter</li> </ul>	
<p><b>MCE Description of Process:</b> Although LHCC has not requested an extension of an expedited or standard appeal since its inception (according to the tracking logs), there is a work process should the need arise. Should that situation arise the Clinical Appeals Coordinator (CAC) will reach out to LDH for their consent and then communicate that delay to the member by phone same day and in writing within two days. Evidence of the work process can be found in the Policy and Procedure governing member appeals along with a copy of the tracking log and the appeals extension template.</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><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> </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 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>	<ul style="list-style-type: none"> <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>LA.QI.11.03 Appeals Process: page 7, section C 1 a.</li> <li>Tracking mechanisms_Element 24</li> <li>LHCC Member Handbook: page 63, section State Fair Hearing for Appeals.</li> </ul>	
<p><b>MCE Description of Process:</b> Although LHCC has not found itself in a position where we failed to adhere to the appeal notice and timing requirements since its inception (according to the tracking logs), there is a work process should the need arise. Should that situation arise the Clinical Appeals Coordinator (CAC) will reach out to the member by phone and in writing advising the member of their right to a state fair hearing. Evidence of the work process can be found in the Policy and Procedure governing member 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>25. For all appeals, the MCE provides written notice of the appeal resolution that includes:</p> <p style="margin-left: 20px;">a. The results of the resolution process and the date it was completed.</p> <p style="margin-left: 20px;">b. For appeals not resolved wholly in favor of the member:</p> <p style="margin-left: 40px;">i. The right to request a SFH, and how to do so.</p> <p style="margin-left: 40px;">ii. The right to request and receive benefits while the hearing is pending, and how to make the request.</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>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>A. LA.QI.11.03 Appeals Process: page 6, section 4</li> <li>Appeal resolution notice template</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>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.</p> <p>MCO:</p> <ul 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 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></li> </ul> <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</i></li> </ul>		



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<p><i>with the PAHP’s decision in response to an appeal, and the process for doing so.</i></p> <p style="text-align: center;">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> LHCC work process regarding notification of an adverse decision regarding an appeal involves telephonic notification as soon as possible following the determination by the Medical Director as well as composing and mailing a LDH approved denial letter. Evidence of the work process can be found in the Policy and Procedure governing member appeals along with a copy of the appeal resolution notice template.</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>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: center;">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>• LA.QI.11.03 Appeals Process: page 6, section f. (1), bullet 2</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> Once a resolution is made, the member is called to discuss the resolution decision, an Appeal Resolution Letter for an Expedited Appeal (which also documents the acknowledgment) is sent out after calling or making a reasonable attempt to call the member to confirm the conversation of the resolution decision.</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>		
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 style="margin-left: 20px;">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 style="text-align: right; margin-right: 20px;">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>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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.03 Appeals Process: page 7, section C-1. a.</li> <li>Appeal resolution notice template</li> <li>LHCC Member Handbook: page 63, section State Fair Hearing for Appeals</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> LHCC communicates the member’s right to a state fair hearing by way of telephonic outreach and in writing following an adverse determination of an appeal investigation. Evidence of the work process can be found in the Policy and Procedures governing appeals as well as in the Member Handbook. LHCC is also including a copy of the appeal resolution template.</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>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>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>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 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>PIHP:</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)</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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 7, section C. 2. a.</li> <li>• Appeal resolution notice template</li> <li>• LHCC Member Handbook: page 63, section State Fair Hearing for Appeals.</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 §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>		
<p><b>MCE Description of Process:</b> LHCC communicates the member’s right to a state fair hearing by way of telephonic outreach and in writing following an adverse determination of an appeal investigation. In that communication LHCC makes note of the 120 days from the denial adverse determination notification Evidence of the work process can be found in the Policy and Procedures governing appeals as well as in the Member Handbook. LHCC is also including a copy of the appeal resolution template.</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>		
Continuation of Benefits		
<p>29. The MCE continues the member’s benefits if all of the following occur:</p> <ol style="list-style-type: none"> <li>a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice).</li> <li>b. The appeal involves the termination, suspension, or reduction of previously authorized services.</li> <li>c. The services were ordered by an authorized provider.</li> <li>d. The period covered by the original authorization has not expired.</li> <li>e. The member timely files for continuation of benefits.</li> </ol> <p>MCO/PAHP/PIHP:</p> <ol style="list-style-type: none"> <li>a. <i>Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.</i></li> </ol> <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</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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 8, Continuation of Benefits section 1</li> <li>• ABD Notice Template</li> <li>• Appeal resolution notice template</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
ABD, or the intended effective date of the MCE’s proposed ABD.  <div style="text-align: right;">42 CFR §438.228 42 CFR §438.420(a-b)</div> MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2		
<b>MCE Description of Process:</b> LHCC’s appeal work process provides for the continuation of benefits in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manual. Evidence supporting alignment with the contract can be found in the Policy and Procedures governing member appeals as well as member communication vis-s-vis ABD and appeal resolution letters (templates provided).		
<b>HSAG Findings:</b> HSAG has determined that the MCE met the requirements for this element.		
<b>Required Actions:</b> No action required.		
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: <ol style="list-style-type: none"> <li>a. The member withdraws the appeal or request for SFH.</li> <li>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.</li> <li>c. A SFH office issues a hearing decision adverse to the member.</li> </ol> MCO and PAHP: <ol style="list-style-type: none"> <li>a. Appeals               <ol style="list-style-type: none"> <li>i. <i>The time period or service limits of a previously authorized service has been met.</i></li> </ol> </li> </ol> <div style="text-align: right;">42 CFR §438.228</div>	<b>HSAG Required Evidence:</b> <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> <b>Evidence as Submitted by the MCE:</b> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeals Process: page 8, Continuation of Benefits section 2</li> <li>• ABD Notice Template</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: 2.15.3.2.2; 2.15.4.8 PAHP Contract: 2.10.3.5; 2.10.6.9 PIHP Contract: 11.6.3	42 CFR §438.420(c)	
<p><b>MCE Description of Process:</b> LHCC’s appeal work process provides for reinstating a member’s benefits in accordance with applicable Federal and State laws, regulations, rules, policies, procedures, and manual. Evidence supporting alignment with the contract can be found in the Policy and Procedures governing member appeals as well as member communication vis-s-vis ABD letters (template 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>		
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.  MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	42 CFR §438.228 42 CFR §438.420(d)	<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>• LA.QI.11.03 Appeals Process: page 8, Continuation of Benefits section 3.</li> <li>• ABD Notice Template</li> <li>• Appeal resolution notice template</li> </ul>
<p><b>MCE Description of Process:</b> LHCC’s appeal work process provides for recovering the costs of the services furnished while the SFH was pending to the extent that the services were furnished solely because of the requirement to continue benefits during the appeal. Evidence supporting alignment with the contract can be found in the Policy and Procedures governing member appeals as well as member communication vis-s-vis ABD letters and appeal resolution letters (templates provided).</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.		
<p>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.</p> <p style="text-align: right;">42 CFR §438.228 42 CFR §438.424(b)</p> <p>MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2</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>• 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>• LA.QI.11.03 Appeals Process: page 8, section Continuation of Benefits section 5.</li> <li>• Staff training material_Element 32</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC’s appeal work process addresses the incidence where 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. Evidence supporting alignment with the contract can be found in the Policy and Procedures governing member appeals. Please note, the SFH Companion Guide has not been updated since 2014.</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.		
Reinstatement of Services		
<p>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 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</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Tracking mechanisms</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>• LA.QI.11.03 Appeals Process: page 8, section D. 4.</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: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1	42 CFR §438.424(a) 42 CFR §457.1260(i) <ul style="list-style-type: none"> <li>Tracking mechanisms_Element 33</li> <li>Tracking mechanisms_Element 33 (2)</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC’s appeal work process addresses the incidence where 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 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. Evidence supporting alignment with the contract can be found in the Policy and Procedures governing member 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>		
Grievances, Appeals, and State Fair Hearings		
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><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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
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><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 4, section The Plan shall refer all Members who are dissatisfied with the Plan or its activities to the Plan’s Grievance system, second paragraph.</li> <li>LA.QI.11.03 Appeals Process: page 2, section A. 3</li> <li>LHCC Member Handbook: page 47, section Translations and Interpreter Services.</li> </ul>	



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>LHCC Member Handbook: page 62, section Who May File an Appeal</li> <li>CSR Work Process</li> </ul>	
<p><b>MCE Description of Process:</b> As outlined in Policy LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process, services are available to support members which may include explaining processes, completing forms on behalf of the member, and ensuring accessibility of all communication. In addition, LHCC provides auxiliary aids and services upon request. As evidence of contract compliance LHCC has provided the Policy and Procedure governing this work process as well as member communication regarding assistance in completing forms and taking other procedural steps related to a grievance vis-à-vis 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>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;">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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.QI.11.02 Grievance Process: page 5, section Language and Format Requirements.</li> <li>LA.QI.11.03 Appeals Process: Appeals Notification Letter: page 6, section 4 (3) bullet 1.</li> <li>Mechanisms to assess reading grade level of member notice- Element 35</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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Requirement	Supporting Documentation	Score
	<ul style="list-style-type: none"> <li>• Appeals Mechanisms Element 35</li> <li>• Grievance and appeal resolution templates, including taglines- Element 35</li> <li>• Appeal resolution notice template</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC utilizes mechanisms to assess the reading grade level of member notices to ensure they meet the required sixth-grade reading level or lower, in accordance with federal guidance. Templates for grievance and appeal resolution notices are pre-designed and reviewed regularly to maintain compliance with these standards. The submitted documentation, including LA.QI.11.02 Grievance Process and LA.QI.11.03 Appeals Process reading level assessment mechanisms, and grievance and appeal resolution templates, demonstrates LHCC’s compliance with regulatory requirements for member-facing communications.</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>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;">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>	<p><b>HSAG Required Evidence:</b></p> <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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• CC.PRVR.13 Provider Orientations: page 1, section Procedure</li> <li>• CC.PRVR.13 Provider Orientations: page 5, section Appeals and Grievances Overview</li> <li>• LHCC Provider Handbook: page 4, section Member Grievances, Provider Complaints, Claim Disputes</li> <li>• PPA Agreement Template: page 4, section 2.4</li> <li>• PPA Agreement Template</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><b>MCE Description of Process:</b> During the new provider contracting and enrollment process, providers are directed to the Provider Manual for information related to LHCC’s grievance and appeals process. As evidence of this work process LHCC is presenting the PPA Agreement as well as 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>37. The MCE includes as parties to the appeal and SFH:</p> <ul 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> </ul> <p style="text-align: right;">42 CFR §438.228            42 CFR §438.406(b)(6)            42 CFR §438.408(f)(3)            42 CFR §457.1260(e)(5)</p> <p>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</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/or notice templates</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.03 Appeal Process: Page 2 Section A.2.</li> <li>• LA.QI.11.03 Appeal Process: Page 7 Section C.1.a.</li> <li>• LHCC Member Handbook: page 62, section Who May File an Appeal</li> <li>• LHCC Member Handbook: page 64, section Legal Services</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> LHCC’s work process for managing member appeals and state fair hearings includes members, their representative and in the case of a deceased member their legal representative. As evidence of this work process LHCC presents the Member Handbook and the Policy and Procedure for managing grievances and 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>		



**Louisiana Department of Health**  
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Standard XIII—Grievance and Appeal Systems		
Requirement	Supporting Documentation	Score
<b>Recordkeeping Requirements</b>		
<p>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:</p> <ol style="list-style-type: none"> <li>a. A general description of the reason for the appeal or grievance.</li> <li>b. The date received.</li> <li>c. The date of each review or, if applicable, review meeting.</li> <li>d. Resolution at each level of the appeal or grievance, if applicable.</li> <li>e. Date of resolution at each level, if applicable.</li> <li>f. Name of the member for whom the appeal or grievance was filed.</li> </ol> <p>PIHP:</p> <ol style="list-style-type: none"> <li>a. Medicaid number</li> <li>b. Summary of grievances and appeals;</li> <li>c. Current status;</li> <li>d. Resolution with date of resolution and resulting corrective action;</li> <li>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;</li> <li>f. The status and resolution of all claims disputes;</li> <li>g. Trends and types of grievances and appeals;</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 Grievances and Appeals File Reviews and the system demonstration</li> </ul> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.QI.11.02 Grievance Process: page 7, section Procedures 5. B</li> <li>• LA.QI.11.02 Grievance Process: page 7, section Recordkeeping and Reporting Requirements</li> <li>• LA.QI.11.03 Appeals Process: page 3, General Requirements section 11</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>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: 50px;">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>MCE Description of Process:</b> LHCC captures all of the information regarding grievance and appeals management in a SharePoint tracking log. Both grievance and appeals data entries have over 40 data points that capture information required by LDH in addition to information required by regulatory agencies such as NCQA. Monthly reports required by LDH pull data from this electronic data management system. As evidence of compliance with this standard LHCC presents the Policy and Procedure governing member 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>		

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

<b>Total Score ÷ Total Applicable</b>	=	<b>100%</b>
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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>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 2 “Fraud, Waste and Abuse Prevention”</li> <li>• MCO_Manual, page 22</li> <li>• PI 145 State Reporting Template</li> <li>• Regulatory Reporting Tracker</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Process Document_State Report Certification_Attestation</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> MCE follows regulatory reporting guidelines as established by LDH and described in MCO manual. MCE submits reports timely and per mandatory guidelines with oversight and attestation from CEO. MCE tracks reporting via Smartsheet.</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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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Compliance Program/Program Integrity Plan</b>		
<p>2. The MCE develops a compliance program that includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>MCO and PAHP:</p> <p>a. <i>Fraud, waste, and abuse training shall include, but not be limited to:</i></p> <p style="margin-left: 20px;">i. <i>Annual training of all employees; and</i></p> <p style="margin-left: 20px;">ii. <i>New hire training within thirty (30) Calendar Days of beginning date of employment.</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> <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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• 2024 Compliance_FWA Training</li> <li>• 2024 SIU Orientation Agenda_Investigator</li> <li>• 2024 SIU Orientation Agenda_Clinical</li> <li>• Louisiana Case Workflow</li> <li>• MCO_Manual, page 243</li> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 5</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
<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> <ul style="list-style-type: none"> <li>i. <i>MCO/PAHP Code of Conduct Training;</i></li> <li>ii. <i>Privacy and Security - Health Insurance Portability and Accountability Act;</i></li> <li>iii. <i>Fraud, Waste, and Abuse identification and reporting procedures;</i></li> <li>iv. <i>The False Claims Act and employee whistleblower protections;</i></li> <li>v. <i>Procedures for Timely consistent exchange of information and collaboration with LDH;</i></li> <li>vi. <i>Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and</i></li> <li>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></li> </ul> <p>c. <i>Effective lines of communication between the compliance officer and the organization's employees.</i></p>	<p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• CC.COMP.10</li> <li>• Code of Conduct training</li> <li>• Privacy and Security Training - Health Insurance Portability and Accountability Act</li> <li>• 2024 FWA Training</li> <li>• PI Org Chart</li> <li>• SIU Committee Charter_rev 09.2024</li> <li>• January SIC Meeting Minutes</li> <li>• February SIC Meeting Minutes</li> <li>• LA_Healthcare_Connections_Provider_Manual</li> </ul>	



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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, Medicaid Fraud Control Unit (MFCU), and contracted External Quality Review Organization (EQRO), if</i></p>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>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> MCE is compliant with all training requirements per MCO contract. All Centene/LHCC employees must attend yearly compliance and FWA training. All new hires to SIU attend extensive training immediately upon hire date both through corporate team training and one-on-one individual training with assigned SIU mentor.</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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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 9-10</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> Comp 16 FWA plan outlines SIU/Compliance program.		
<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. Additional compliance program requirements:  MCO:</p> <p style="margin-left: 20px;">a. <i>The MCO's compliance program shall incorporate the following requirements:</i></p> <p style="margin-left: 40px;">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: 40px;">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</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>• MCO_Manual, page 242 - 244</li> <li>• SOP 5.1 Intake-Triage (Non-Rx)_10.15.24</li> <li>• SOP 6.0 - Preliminary Investigation_6.6.2025</li> <li>• 5.8.24 SOP 6.0 - Preliminary Investigation</li> <li>• 7.12.24 SOP 6.0 - Preliminary Investigation</li> <li>• 8.4.23 SOP 6.0 - Preliminary Investigation</li> <li>• CC.Comp.16_FWA_Plan_11.05.2024, page 2-4. 6-7, Page 9-10</li> <li>• CC.COMP.16.01_Service_Verification_20242407</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<p><i>provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement.</i></p> <p>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 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><b>PAHP:</b></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>	<ul style="list-style-type: none"> <li>• HCFS_BusinessRules_6282024</li> <li>• LHCC Analytics Capabilities</li> <li>• SOP 25.0 Onsite Audits_1.3.23</li> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 9-10</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan</li> <li>• SOP 7.1 CASE SAMPLING PROCESS</li> <li>• SOP 13.1 PREPAYMENT REVIEW (ANALYST)</li> <li>• HCFS_BusinessRules_6282024</li> <li>• SOP 25.0 Onsite Audits</li> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan, Page 16</li> </ul>	



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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> <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>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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> <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> Multitude of methods used to identify and prevent FWA through both SIU and health plan units. SIU utilizes Healthcare Fraud Shield (HCFS) for case documentation, data analytics, predictive modeling which include numerous algorithms for identifying FWA indicators. Health Plan units similarly utilize variety of analytic capabilities (list attached) to identify potential fraud indicators. SIU SOP’s outline preliminary investigative steps and case triage. MCE follows outlined required reporting for fraud referrals to LDH and MFCU with mandatory immediate report of confirmed instances of fraud or abuse. On-site audits practices and guidelines are established and included in SIU SOP.</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. 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>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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Louisianahealthconnect.com/providers/resources/report-fraud.html</li> </ul>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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>	<ul style="list-style-type: none"> <li>Reporting Fraud – member resources</li> <li>CC.Comp.16_FWA_Plan_11.05.2024, page 4</li> <li>Copy of email submission of yearly FWA Compliance plan to LDH titled “2025 FWA Compliance Plan”</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan, Page 12</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC member website (<a href="https://www.louisianahealthconnect.com/members/medicaid/resources/reducing-fraud.html">https://www.louisianahealthconnect.com/members/medicaid/resources/reducing-fraud.html</a>) includes instructions for reporting fraud. LHCC submits yearly Compliance/FWA plan to LDH Program 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>		



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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Overpayments and Treatment of Recoveries</b>		
<p>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.</p> <p style="text-align: right;">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>	<p><b>HSAG Required Evidence:</b></p> <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> <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>MCE_Monthly_Overpayments_and_TIPS_Report_413_MCO_Monthly</li> <li>PI 145 State Reporting Template</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> LHCC submits required reports per MCO Manual guidelines for monthly and quarterly overpayments identified and recovered via 143 and 145 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>		



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Requirement	Supporting Documentation	Score
<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> <p>a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments.</p> <p>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.</p> <p>c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.</p> <p>MCO:</p> <p>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></p> <p>PAHP:</p> <p>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></p> <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><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>• MCE_Monthly_Overpayments_and_TIPS_Report_413_MCO_Monthly</li> <li>• PI 145 State Reporting Template</li> <li>• MCO Manual, page 242</li> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 8</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
<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>		
<p><b>MCE Description of Process:</b> LHCC submits required reports per MCO Manual guidelines for monthly and quarterly overpayments identified and recovered via 143 and 145 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>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</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> </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>identified, and to notify the MCE in writing of the reason for the overpayment.</p> <p style="text-align: right;">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>	<ul style="list-style-type: none"> <li>Staff training materials</li> </ul> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA_Healthcare_Connections_Provider_Manual: page 149-Self Disclosure Provider Overpayments.</li> <li>2025 Q1 145 CLAIM DATA</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan</li> <li>Narrative: In response to audit performed by LDH, process improvement guidance was given. Beginning with the Q2 2025 145 report, we updated our process and expanded the descriptions in the “Reason for Recovery” column on the W&amp;E Tab. LHCC is verifying all projects that meet requirements for reporting on W&amp;E tab are being captured and will be included.</li> </ul>	
<p><b>MCE Description of Process:</b> A provider who identifies an overpayment shall report the overpayment and return the entire amount to Louisiana Healthcare Connections within 60 days after it is identified. MCE includes provider self-audit on LHCC Waste and Error tab of the quarterly 145 report.</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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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<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 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> <p style="margin-left: 20px;">a. Changes in the member’s residence;</p> <p style="margin-left: 20px;">b. The death of a member.</p> <p style="text-align: right; margin-right: 20px;">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>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>PI 145 State Reporting Template</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>Disenrollments Process Flow Chart</li> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan - Page 5, number 8</li> <li>Narrative: When LHCC is made aware of circumstances that may affect the member’s eligibility, such as changes in the member’s residence and/or death of the member, this information is sent over as PHI updates to LDH via LaMeds Reporting. After the data is sent to the State, LDH makes the determination to disenroll the member. This Disenrollment is then sent back to the MCO to formally disenroll the member via the 834 Eligibility Data files. Until the MCO receives an 834 disenrollment, LHCC cannot disenroll the member.</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 includes Provider Self-Audits and Unsolicited Refunds, LHCC Waste and error reporting on quarterly 145.</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>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><b>PAHP:</b></p> <p>a. <i>The PAHP shall notify LDH within seven (7) calendar days of any unexpected changes (e.g., a provider 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> <p style="margin-left: 20px;">i. <i>Information about how the provider network change will affect the delivery of covered services; and</i></p> <p style="margin-left: 20px;">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></p> <p><b>PIHP:</b></p> <p>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</i></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> <ul style="list-style-type: none"> <li>• LA.Cont.02 – Network Selection and Retention – Pages 9-10s, Sections 63, 64, &amp; 65</li> <li>• Provider Contract Termination Overview</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>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></p> <ul 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> </ul> <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>		
<p><b>MCE Description of Process:</b> LHCC provides notice to LDH in any unexpected changes of a provider’s circumstances with information on how the provider network change will affect the delivery of covered services and LHCC’s plan for maintaining the quality of member care, if applicable.</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</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><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> NA</p>



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Requirement	Supporting Documentation	Score
<p>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> <ol 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> </ol> <p>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></p> <p>c. <i>The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).</i></p>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• LA.COMP.16.01_EOB_Service_Verification_11.20 24pgs. 1-2</li> <li>• LA.CLMS.07 pg. 2</li> <li>• CC.COMP.16_FWA_Plan.11.05.2024 pgs. 4, 7, 11</li> <li>• 147 LHCC 2024 Q4</li> <li>• LDH Report 147 Standard Operating Procedure-SOP</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Daily Mail Tracker for Payment Integrity forms - Service Verification Letters (Screenshot)</li> <li>• Daily Mail Tracker for Payment Integrity forms - Service Verification Letters 2 (Screenshot)</li> </ul>	



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<p>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></p> <p>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 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>PAHP:</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> </ul>		



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Requirement	Supporting Documentation	Score
<p>iv. <i>The amount of the payment made for the service.</i></p> <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> <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>		



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Requirement	Supporting Documentation	Score
<p>PIHP:</p> <ul style="list-style-type: none"> <li>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> <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> </li> <li>b. <i>The Contractor shall stratify the sample to ensure that all provider types are represented in the same pool. The 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></li> <li>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></li> <li>d. <i>The Contractor shall over sample particular provider groups upon request by LDH.</i></li> <li>e. <i>The Contractor shall track any feedback received from members. The Contractor shall use the feedback</i></li> </ul>		



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Requirement	Supporting Documentation	Score
<p><i>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> <p style="text-align: right;">42 CFR §438.608(a)(5)</p> <p>MCO Contract: 2.20.2.2.10; 2.18.11.1            PAHP Contract: 2.14.6.            PIHP Contract: 15.4</p>		
<p><b>MCE Description of Process:</b> LHCC adheres to the guidelines and processes required by the applicable regulations and MCO Model Contract regarding service verification, as outlined in the policies provided. LHCC selects a sample of members to receive a Service Verification (SV) for review and provides the 147 report quarterly report to LDH regarding the EOB results.</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 align the LA.COMP.16.01_EOB_Service_Verification policy and the LA.CLMS.07 policy so they both include all requirements of this element.</p>		
<p><b>Required Actions:</b> No action required.</p>		



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Requirement	Supporting Documentation	Score
<b>Whistleblower Protection</b>		
<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 style="padding-left: 20px;">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 style="text-align: right; padding-right: 20px;">42 CFR §438.608(a)(6)</p> <p>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>	<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> <hr/> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>Louisiana Subcontractor Product Attachment VM</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>2024 Code of Conduct</li> <li>LA.COMP.16_Fraud_Waste_and_Abuse_Plan</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> All delegated vendors must have the Louisiana Subcontractor Product Attachment incorporated as part of their agreement.</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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Standard XIV—Program Integrity		
Requirement	Supporting Documentation	Score
<b>Fraud, Waste, and Abuse</b>		
<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 standardized referral process should be developed to expedite information for appropriate disposition.</i></p> <p style="text-align: right;">42 CFR §438.608(a) 42 CFR §438.608(a)(7)</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>• MCO_Manual, page 242</li> <li>• 2024 MCE Fraud Referral</li> <li>• MCE Fraud Referral Template_3.24.25</li> <li>• LA.COMP.16_Fraud_Waste_and_Abuse_Plan_-_5.14.24, page 8-10</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• Fraud Referral Template</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
MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4		
<b>MCE Description of Process:</b> MCE follows the process established by MCO Manual for reporting FWA.		
<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;">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> <p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>• Provider Preclusions, Exclusions, Suspensions, and Sanctions - Network Operations Work Process</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LA_Healthcare_Connections_Provider_Manual (Identified in virtual review)</li> </ul>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<b>MCE Description of Process:</b> The LHCC PDM team monitors our central inbox for exclusion and sanction notices received from LDH. Upon receipt of the notice from LDH, the LHCC PDM team reviews the paperwork to determine the provider and what actions must be taken by LHCC. The LHCC PDM team will then enter this information in the following places the External Notification Tracker, the JIRA ticketing system, and the CenProv ticketing system. The LHCC PDM team monitors the CenProv ticket to ensure completion of the request before closing out the JIRA ticket and notifying internal staff about the applied sanction or exclusion. Copies of the notices received from LDH are also archived for record retention.		
<b>MCE Description of Process:</b> MCE follows the process established by MCO Manual for reporting FWA.		



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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>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;">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>Provider Preclusions, Exclusions, Suspensions, and Sanctions - Network Operations Work Process</li> <li>External Notification Tracker Screenshots</li> <li>Exclusion Letter #1 Example</li> <li>Exclusion Letter #2 Example</li> </ul>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> NA
<p><b>MCE Description of Process:</b> The letter sent by LDH to the MCOs is a copy of the letter issued to the provider or practitioner by LDH informing them they are excluded from participating in the Medicaid program. This letter speaks to the requirements outlined in 42 CFR §455.23(b). A copy of this letter is archived by LHCC in accordance with 42 CFR §455.23(c). As such LHCC does not send an additional letter as this would be redundant.</p>		
<p><b>HSAG Findings:</b> HSAG has determined that the MCE has not met the requirements for this element. LHCC stated that it is not responsible for issuing notices of payment suspension and did not submit a policy demonstrating compliance with the requirements. Of note, LDH confirmed that this is a contract requirement.</p>		



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Requirement	Supporting Documentation	Score
<p><b>Required Actions:</b> The MCE must develop a policy for issuing 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>		
<b>Provider Screening and Enrollment Requirements</b>		
<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;">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>• LA.Cont.02 – Network Selection and Retention – Page 4, Section 20.</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>• LA Suppression Sweep Business rules</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> LHCC and its subcontractors will not enter into a network provider agreement with a provider when the provider is not otherwise appropriately screened.</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. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days.</p> <p>a. The MCE terminates a network provider immediately upon notification from LDH that the network provider</p>	<p><b>HSAG Required Evidence:</b></p> <ul style="list-style-type: none"> <li>• Policies and procedures</li> <li>• Medicaid enrollment timeliness tracking mechanisms</li> <li>• Staff training materials</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>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;">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>	<p><b>Evidence as Submitted by the MCE:</b></p> <ul style="list-style-type: none"> <li>LA.Cont.02 – Network Selection and Retention – Page 4, Section 22</li> <li>Provider Contract Termination Overview</li> </ul>	
<p><b>MCE Description of Process:</b> LHCC may execute network provider agreements pending the outcome of the State screening, enrollment, and re-validation process of up to 120 calendar days, but if notification from LDH that a provider’s enrollment has been denied or terminated, or the expiration of the 120 days, LHCC will terminate that network provider immediately and notify affected members in writing that the provider is no longer participating in the network.</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>		
Disclosures and Prohibited Affiliations		
<p>18. The MCE, and any subcontractors:</p> <ol style="list-style-type: none"> <li>Provides written disclosure of any prohibited affiliation under 42 CFR §438.610.</li> <li>Provides written disclosures of information on ownership and control required under 42 CFR §455.104.</li> <li>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> </ol> <p>MCO:</p> <ol style="list-style-type: none"> <li><i>Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars</i></li> </ol>	<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>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



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Requirement	Supporting Documentation	Score
<p><i>(\$25,000), even if there is no suspicion of fraudulent activity.</i></p> <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>	<ul style="list-style-type: none"> <li>Louisiana Subcontractor Product Attachment VM</li> <li>MediTrans_DOO_Redacted.pdf</li> </ul> <p><b>Additional Documentation:</b></p> <ul style="list-style-type: none"> <li>LA.COMP.27_Ownership_and_Management_Disclosure_09.10.2024</li> </ul>	
<p><b>MCE Description of Process:</b> All delegated vendors must have the Louisiana Subcontractor Product Attachment incorporated as part of their agreement. When these contracts are developed and submitted to the state, it is always done so with the Disclosure of Ownership form completed by the entity. Sample of MediTrans DOO is 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>		

Results for Standard XIV—Program Integrity							
<b>Total</b>	Met	=	17	X	1	=	17
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
<b>Total Applicable</b>	=	18	<b>Total Score</b>	=	17		
<b>Total Score ÷ Total Applicable</b>						=	<b>94%</b>



## Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	Evidence as Submitted by the MCE		Score
1.  Contract: <Insert Citation(s)>	<b>MCE Document Submission:</b> • <Insert federal CFR citation>		<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>			