LOUISIANA DEPARTMENT OF HEALTH

2025 External Quality Review Compliance Review

for

UnitedHealthcare Community

December 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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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).[1]

[1] 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 UnitedHealthcare Community (UHC). 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	7	2	3	78%
II	Member Rights and Confidentiality	24	24	24	0	0	100%
III	Member Information	19	18	13	5	1	72%
IV	Emergency and Poststabilization Services	13	13	13	0	0	100%
V	Adequate Capacity and Availability of Services	15	14	2	12	1	14%
VI	Coordination and Continuity of Care	12	12	9	3	0	75%
VII	Coverage and Authorization of Services	23	21	13	8	2	62%
VIII	Provider Selection	19	19	12	7	0	63%
IX	Subcontractual Relationships and Delegation	6	6	5	1	0	83%
X	Practice Guidelines	6	6	5	1	0	83%
XI	Health Information Systems	9	9	7	2	0	78%
XII	Quality Assessment and Performance Improvement	13	11	11	0	2	100%
XIII	Grievance and Appeal Systems	38	37	31	6	1	84%
XIV	Program Integrity	18	18	16	2	0	89%
Total Compliance Score		**227**	**217**	**168**	**49**	**10**	**77%**

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	✓	✓	✓				-	✓	✓	✓

[1] 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

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

Appendix A. Conclusions and Recommendations

Strengths	
+	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 could assist them in accessing 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 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.
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 UHC's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, the actions required to bring UHC's performance into full compliance.

Standard I—Enrollment and Disenrollment Requirements and Limitations

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the MCE		
1. The MCE may request disenrollment of a member in the following circumstances: a. *When the member ceases to be eligible for medical assistance under the State Plan as determined by the Department* b. *Upon termination or expiration of the Contract* c. *Death of the member* d. *Confinement of the member in a facility or institution when confinement is not a covered service under the Contract* PAHP: *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).* PIHP: a. *The PIHP may not disenroll CSoC members for any reason other than discharge from CSoC.* 42 CFR §438.56(b)(1)	**HSAG Required Evidence:** • Policies and procedures • State-specific workflow for MCE-initiated disenrollment requests • Member materials, such as the member handbook • 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 *MCE Description of Process*) **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations, page 2, third paragraph	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1212 MCO Contract: 2.3.12.3.2 PAHP Contract: 2.3.7.3.5; 2.3.7.3.1 PIHP Contract: 10.1.6		
MCE Description of Process: UHC does not routinely initiate member disenrollment requests. While policies and procedures are in place to support disenrollment in accordance with LDH and federal guidelines—such as when a member loses Medicaid eligibility, the contract ends, the member is deceased, or is confined in a non-covered facility—UHC did not submit any disenrollment requests in calendar year 2024. This information is not included in the Member Handbook, as UHC does not initiate disenrollments.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE does not request disenrollment because of: MCO & PAHP: a. An adverse change in the member's health status; or b. Because of the member's health diagnosis c. The member's utilization of medical services d. The member's diminished mental capacity e. The member's pre-existing medical condition f. The member's refusal of medical care or diagnostic testing g. The member's attempt to exercise his/her rights under the Contractor's Grievance system h. The member's attempt to exercise his/her right to change, for cause, the PCP that he/she has chosen or been assigned 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	**HSAG Required Evidence:** • Policies and procedures • 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 *MCE Description of Process*) **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations, page 2, third paragraph • UHC Member Disenrollment Policy_LA_2025 Standard I: Procedure, Member Disenrollment, page 2, Section 2, bullet point	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
ability to furnish services to either this particular member or other members). PIHP: a. The member's adverse change in health status b. The member's utilization of medical services c. The member's diminished mental capacity d. The member's uncooperative or disruptive behavior resulting from his or her special needs 42 CFR §438.56(b)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.3.4 PAHP Contract: 2.3.7.3.4 PIHP Contract: 10.1.5		
MCE Description of Process: UHC does not routinely initiate member disenrollment requests. Policies and procedures show that UHC would not disenroll members based on health conditions or how often they use their benefits. No disenrollment requests were submitted by UHC in the calendar year 2024.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Both the Member Enrollment and Disenrollment Policy and the Disenrollment Policy were out of the scope of 2024 and, during the virtual review, staff members indicated that the annual policy review process had not been conducted for these policies. In addition, both policies were missing some of the requirements of this element. **Recommendations:** HSAG recommends that the MCE combine these two policies into a single policy that specifies all requirements.		
Required Actions: The MCE must update the Member Enrollment and Disenrollment Policy, the Disenrollment Policy (and consider combining them into a single policy), and any other applicable documents to include the requirements of this element.		
3. The MCE assures the State that it does not request disenrollment for reasons other than those permitted under the contract. MCO & PAHP:	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • One case example of an MCE-initiated request for disenrollment of a member, including supporting	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
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. PIHP: 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. 42 CFR §438.56(b)(3) 42 CFR §457.1212 MCO Contract: 2.3.13.3.5 PAHP Contract: 2.3.7.3.5 PIHP Contract: 10.1.6	documentation of the reason for the request and the outcome of the disenrollment request **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations, page 2, 4th paragraph	
MCE Description of Process: UHC does not initiate member disenrollment requests. The Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I indicates that UHC does not request disenrollment for reasons other than those permitted under the contract. No disenrollment requests were submitted by UHC in the calendar year 2024.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Member Enrollment and Disenrollment Policy and the Disenrollment Policy (and consider combining them into a single policy) to include the requirements of this element.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Disenrollment Requested by the Member		
4. The member may request disenrollment from the MCE as follows: a. Without cause, at the following times: MCO: i. During the disenrollment period offered to Enrollees at the start of the contract. 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. iii. At least once every 12 months thereafter (during the enrollment period). iv. At least once every 12 months thereafter. 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. 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.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations, page 3, 2nd paragraph • LA_IntegratedHealthServices_Handbook-Standard 1, page 64, Disenrollment options, Disenroll from UnitedHealthcare Community Plan section, 2nd paragraph	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
vii. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. PAHP: 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. ii. At least once every 12 months thereafter. iii. Upon automatic enrollment under 42 CFR §438.56(g) if the temporary eligibility has caused the member to miss the annual disenrollment opportunity. 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. v. After the State notifies the Contractor that it intends to terminate the Contract as provided by 42 CFR §438.722. 42 CFR §438.56(c) 42 CFR§438.56(g) 42 CFR §438.702(a)(4) 42 CFR §457.1212 MCO Contract: 2.3.13.2.2 PAHP Contract: 2.3.7.2.2 PIHP Contract: NA		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The handbook has information on member rights around disenrollment and how a member may request disenrollment (must contact LDH). The internal Member Enrollment and Disenrollment policy contains the disenrollment rules and shows what happens when that disenrollment request is sent to UHC by LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Procedures for Disenrollment		
5. The following are causes for disenrollment: MCO: a. The member moves out of the MCE's service area; b. The MCE does not (due to moral or religious objections) cover the service the member seeks; 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; d. Poor quality of care; e. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; f. The Contract between the MCE and LDH is terminated; 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations, page 2, 4th paragraph • LA Integrated Member Handbook Standard I: Disenrollment options, Disenroll from UnitedHealthcare Community Plan section, page 64, 3rd paragraph AND page 64 1st paragraph	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
h. Any other reason deemed to be valid by LDH and/or its agent. PAHP: a. The MCE does not (due to moral or religious objections) cover the service the member seeks; 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; c. Poor quality of care; d. Lack of access, or lack of access to providers experienced in dealing with the member's specific needs; e. The Contract between the MCE and LDH is terminated; f. Any other reason deemed to be valid by LDH and/or its agent. 42 CFR §438.56(d)(2) 42 CFR §457.1212 MCO Contract: 2.3.13.2.1 PAHP Contract: 2.3.7.2.1 PIHP Contract: NA		
MCE Description of Process: The member handbook outlines the rights of members around specific circumstances under which disenrollment may occur. Additionally, the internal Member Enrollment and Disenrollment policy details the allowable causes for disenrollment, consistent with regulatory and contractual requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
6. The member must request disenrollment by submitting an oral or written request (as required by the State): a. To the State or its agent; or b. To the MCE, if the State permits MCEs to process disenrollment requests. 42 CFR §438.56(d)(1) 42 CFR §457.1212 MCO Contract: 3.1.12.4.1.2 PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow delineating State and MCE responsibilities • Three examples of member disenrollment requests (e.g., MCE/State-required form, screenshots of documented requests, submitted member letter) **Evidence as Submitted by the MCE:** • LA Integrated Member Handbook Standard I: Disenrollment options, Disenroll from UnitedHealthcare Community Plan section, pg 65, after bullet points • UHC Member Disenrollment Policy_LA_2025 Standard I: Policy section, page 1, 4th paragraph • UHC_Disenrollment_SOP_Member_Service pg 3 & 8	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The member handbook outlines how a member may request disenrollment from the plan, including both oral and written methods, as permitted by the State. The UHC_Disenrollment_SOP_Member_Service provides Member Service Advocates (MSAs) guidance on how to handle a member's oral request to switch to another MCO, disenroll following initial enrollment, and moves out of state. MSAs do not process disenrollment requests; instead, they offer guidance and assistance with any plan-related concerns before disenrollment.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.56(d)(3)(i) 42 CFR §457.1212 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • 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) **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Not allowed per contract		
HSAG Findings: 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.		
Required Actions: No action required.		
Use of the MCE's Grievance Process		
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: 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.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Three case examples of a member request for disenrollment grievance record, including the resolution letter • Referrals to the State for member termination from MCE • Report of member disenrollment requests during the past 12 months, including the reason for the disenrollment (e.g., grievance report)	☐ Met ☐ Not Met ☒ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.56(d)(5)(i-ii) 42 CFR §438.56(e)(1) 42 CFR §457.1212 MCO Contract: 2.15 PAHP Contract: NA PIHP Contract: NA	**Evidence as Submitted by the MCE:** • N/A	
MCE Description of Process: Not in contract.		
HSAG Findings: The State contract does not require a grievance process as described in these requirements; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
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. 42 CFR §438.56(d)(3)(ii) 42 CFR §457.1212 MCO Contract: 2.3.13.4.2 PAHP Contract: 2.3.7.4.2 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: Not in contract.		
HSAG Findings: The MCE is not responsible for making disenrollment determinations; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Enrollment		
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. MCO and PAHP: a. *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).* PIHP: a. *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.*	**HSAG Required Evidence:** • **Evidence as Submitted by the MCE:** • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, pages 1, first sentence, and, A. Eligibility for Enrollment and Disenrollment Determinations section, page 1, last paragraph, and page 2, first 2 paragraphs	☒ Met ☐ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.3(d)(1) MCO Contract: 2.3.12.1.2 PAHP Contract: 2.3.4.1.2 PIHP Contract: 10.1.2		
MCE Description of Process: The Internal Member Enrollment and Disenrollment process affirms that UHC accepts individuals for enrollment strictly in the order in which applications are received, without restriction, unless otherwise authorized by the Department. The process prohibits prescreening or selection of potential members based on pre-existing health conditions or healthcare needs.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.3(d)(3-4) MCO Contract: 2.3.12.1.3 PAHP Contract: 2.3.4.1.3 PIHP Contract: 10.1.3; 10.1.4	**HSAG Required Evidence:** • Enrollment policies and procedures • Member handbook **Evidence as Submitted by the MCE:** • LA Integrated Member Handbook Standard I: page 87, Other Plan Details, Discrimination is against the law section, first paragraph • Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I: section V. Procedure, A. Eligibility for Enrollment and Disenrollment Determinations section, page 2, paragraph 2.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHC maintains a strict non-discrimination policy that prohibits any form of discrimination against individuals based on health status, healthcare needs, race, color, national origin, sex, sexual orientation, age, disability, or religious belief. This policy applies to all aspects of enrollment, reenrollment, and disenrollment. The policy is operationalized through the Eligibility and Enrollment _Member Enrollment and Disenrollment Policy Standard I, which explicitly states that UHC does not implement or permit any policy or practice that results in discrimination—either directly or indirectly—against any individual seeking or maintaining enrollment.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
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. MCO: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date of the disenrollment; iii. An instruction that the Enrollee choose a new MCO; and 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. PAHP: a. The notice shall include: i. The reason for the disenrollment; ii. The effective date; iii. An instruction that the enrollee choose a new DBPM; and 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. 42 CFR §438.56(d)(5) MCO Contract: 2.3.13.3.7 PAHP Contract: 2.3.7.3.7 PIHP Contract: NA	**HSAG Required Evidence:** • Enrollment policies and procedures • Member notification letter template **Evidence as Submitted by the MCE:** • UHC Member Disenrollment Policy_LA_2025 Standard I: Procedure, Member Disenrollment, page 3, Section 5	☐ Met ☒ Not Met ☐ NA

Standard I—Enrollment and Disenrollment Requirements and Limitations		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UHC does not initiate disenrollment requests for members. While internal policies and procedures are in place to support the disenrollment process if such a request were ever necessary, no disenrollment requests have been submitted by UHC in 2024. There isn't a letter template since UHC does not request member disenrollments. However, should a disenrollment request be submitted and approved by the Department in the future, UHC's policy ensures that the member would receive a written notice at least 30 days prior to the effective date of disenrollment. This notice would include the reason for the proposed disenrollment, effective date, how to choose a new MCO, and inform the member of their right to request a State Fair Hearing.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The policy failed to specify the required inclusions for the notification letter and that the member will be given 30 days' notice. Furthermore, UHC did not have a letter template in case it would need to provide notice.		
Required Actions: The MCE must update policies and applicable documents to comply with the requirements of this element and develop a compliant letter template.		

Results for Standard I—Enrollment and Disenrollment Requirements and Limitations							
Total	Met	=	7	X	1	=	7
	Not Met	=	2	X	0	=	0
	Not Applicable	=	3				
Total Applicable		=	9	**Total Score**		=	7

Total Score ÷ Total Applicable	=	**78%**

Standard II—Member Rights and Confidentiality

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
General Rule		
1. The MCE has written policies regarding member rights. 42 CFR §438.100(a)(1) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 2.9.1.9 PIHP Contract: 5.13.2.2	**HSAG Required Evidence:** • Member rights policy **Evidence as Submitted by the MCE:** • UHC Marketing Enrollee PP (Enrollee Services: Enrollee Rights and Responsibilities pg.6) **Additional Documentation:** • Member Rights and Responsibilities Member Services • Community Plan Handbook Training_V.2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare Community Plan maintains written policies on member (Enrollee) rights and responsibilities that fully comply with applicable Federal and State laws, regulations, and requirements. These rights and responsibilities are clearly stated in our marketing Enrollee Policies and Procedures as well as communicated in the Member Handbook.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.100(a)(2) 42 CFR §457.1220 MCO Contract: 2.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Provider materials, such as the provider manual, provider contract, and provider training materials • Employee training materials • Auditing/oversight mechanisms	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.9.1.9; 2.6.9.13; 6.7.1 PIHP Contract: 5.13.2.4	• Grievance log over the time period of review with member rights grievances **Evidence as Submitted by the MCE:** • UHC Provider Manual 2024 (Chapter 8 pg.78: Enrollee rights and responsibilities section) • Member Rights and Responsibilities Job-aid Process and Procedure (entire document) • Case Management and National New Hire Training- Community Plan Handbook Screenshot **Additional Documentation:** • LA Member Rights Grievance Log • Member Rights and Responsibilities Member Services • Community Plan Handbook Training_V.2 • Attestation that MCE is implementing a formalized annual training and review process beginning September 11, 2025.	
MCE Description of Process: UnitedHealthcare ensures compliance with all applicable Federal and State laws regarding member rights by embedding these rights and responsibilities into the provider manual and requiring contracted providers to uphold them. Internally, staff receive comprehensive training and job-aid practices, processes, and procedural guidelines to promote consistent understanding and application of member rights across our health plan and organization.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Specific Rights		
3. The MCE complies with the requirements listed in the Member Rights Checklist. 42 CFR §438.100(b-d) 42 CFR §457.1220 MCO Contract: 2.13.1.1 PAHP Contract: 2.9.2.1.1; 6.4 PIHP Contract: 5.13.1.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • HSAG will also use the results of the Member Rights Checklist **Evidence as Submitted by the MCE:** • Marketing Enrollee Education PP (Enrollee Services: Enrollee Rights and Responsibilities pg.6) • EQRO Integrated Member Handbook (Member rights and responsibilities pg. 68) • UHC Provider Manual 2024 (Chapter 8 pg.78: Enrollee rights and responsibilities section)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare Community Plan maintains written policies on Enrollee rights and responsibilities that align with all applicable Federal and State requirements. These rights are documented in both the Member Handbook and Provider Manual and are developed based on a detailed checklist outlined in the MCO manual to ensure consistency and compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
General Rule		
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	**HSAG Required Evidence:** • Policies and procedures (should address all components of 45 CFR part 164 subpart E)	☒ Met ☐ Not Met

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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. a. The MCO designates a privacy official who is responsible for the development and implementation of the policies and procedures of the MCO. 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. 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. d. The MCO has appropriate administrative, technical, and physical safeguards to protect the privacy of PHI. 42 CFR §438.224 42 CFR §457.1110 45 CFR §164.530 45 CFR Parts 160 and 164, Subparts A and E MCO Contract: 6.22 PAHP Contract: 2.1.4.1 PIHP Contract: 20.12	• Workflow for adhering to State law for addressing confidentiality of information about minors, privacy of minors, and substance use disorder records • Provider materials, such as provider contract and provider manual, requiring providers to have mechanisms to guard against unauthorized or inadvertent disclosure of confidential information • Employee-facing materials • Staff training materials **Evidence as Submitted by the MCE:** • UHC Provider Manual 2024 (Privacy Regulation section pg. 79) • UHC LA HIPPA Job-aid (document) • HIPAA Guidelines for All Callers (document) • UHC Privacy Policy P16 - Privacy Safeguards, entire document • UHC Privacy Policy P17 - Privacy Training, entire document • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, section A2, page 2 • UHG Privacy Policy Manual, section 1.100, page 1, section 1.200, page 2 • UHC Safe & Secure With Me – Information Privacy_2024 Training Content	☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• UHC Safe & Secure With Me – Information Privacy & Health Care Fraud, Waste and Abuse and Code of Conduct _2024 Annual Training Attestations **Additional Documentation:** • UnitedHealth Group Privacy and Security Overview • Shared Infrastructure_2025_HITRUST r2 Cert	
MCE Description of Process: We ensure compliance with HIPAA privacy requirements through comprehensive policies and procedures and a designated privacy official and contact for privacy-related inquiries and complaints. Our organization supports this framework with job-aids/workflows addressing confidentiality of our members and their records, and our provider manual includes language that require safeguards against unauthorized disclosures. In addition to robust administrative, technical, and physical safeguards, our staff receive role-specific training to ensure the secure handling of Protected Health Information (PHI). The plan has a designated privacy official as outlined in the UHG Privacy Policy Manual and has policy and procedures in place to manage privacy complaints. In addition, the plan has privacy safeguards in place. Staff go through ongoing privacy training as well as annual comprehensive training on information privacy and security.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosure of PHI		
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: a. To the individual.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
b. For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR §164.506. 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). 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. e. Pursuant to an agreement under, or as otherwise permitted by 45 CFR §164.510. f. As permitted by and in compliance with 45 CFR §164.512, §164.514(e), (f), or (g). 45 CFR §164.502(a)(1-3) 45 CFR §164.502(a)(5)(i) 45 CFR §164.502(b) 45 CFR §164.506 45 CFR §164.508 45 CFR §164.510 45 CFR §164.512 45 CFR §164.514(d-g) 45 CFR §164.530(c)(2)(ii) 42 CFR §457.1110(a-b) 45 CFR §160 Subpart C MCO Contract: 6.22; 6.23 PAHP Contract: 2.1.4.1; 2.1.4.2 PIHP Contract: 20.12.2	**Evidence as Submitted by the MCE:** • HIPAA Job Aid Member Service – All Pages • UHC Privacy Policy P3 - Minimum Necessary, entire document • UHC Privacy Policy P9 - UHC Disclosures to Third Parties Policy, entire document • UHC Privacy Policy P22 - Business Associate Contracting, entire document • UHG Privacy Policy Manual, sections 2.100-2.1130, pages 10 through 28 • UHC Safe & Secure With Me – Information Privacy_2024 Training Content • UHC Safe & Secure With Me – Information Privacy & Health Care Fraud, Waste and Abuse and Code of Conduct _2024 Annual Training Attestations • BAA Template for Vendor 2024 • Care Angel Master Services Agreement, Exhibit C, page 31	
MCE Description of Process: The plan has policies and procedures in place to ensure that PHI may not be used or disclosed except as permitted by 45 CFR §164.502 or by 45 CFR §160 subpart C by the plan or its business associates. UnitedHealthcare meets this standard by implementing strong safeguards within our business agreement practices and by delivering comprehensive staff training supported by detailed		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
job aids. For example, our Member Service Advocates (MSAs) follow strict authentication protocols as outlined in the HIPAA Job Aid Member Service, ensuring consistent adherence to HIPAA requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE, and its business associate as permitted or required by its business associate contract, is required to disclose PHI: a. To an individual, when requested under, and required by 45 CFR §164.524 or §164.528. b. When required by the Secretary to investigate or determine the MCE's compliance with 45 CFR §160 subpart C. 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 MCO Contract: 6.23 PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Business associate agreement template • One example of an executed business associate agreement **Evidence as Submitted by the MCE:** • UHC Privacy Policy P22 - Business Associate Contracting, entire document • UHG Privacy Policy Manual, section 1.400-1.440, pages 3 through 6 • BAA Template for Vendor 2024 • Care Angel Master Services Agreement, Exhibit C, page 31 • UHC Safe & Secure With Me – Information Privacy_2024 Training Content • UHC Safe & Secure With Me – Information Privacy & Health Care Fraud, Waste and Abuse and Code of Conduct _2024 Annual Training Attestations	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare adheres to this requirement by implementing processes, staff training, and business agreements that ensure Protected Health Information (PHI) is disclosed appropriately. This includes honoring individual requests for access and accounting of disclosures in accordance with 45 CFR §§164.524 and 164.528, as well as cooperating fully with investigations or compliance reviews conducted by the Secretary under 45 CFR §160 Subpart C. These safeguards support our commitment to privacy, transparency, and regulatory compliance.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Minimum Necessary		
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. 45 CFR §164.502(b) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Three examples of requests for PHI from another covered entity (e.g., member's previous MCE, dental benefits administrator, provider) **Evidence as Submitted by the MCE:** • UHC Privacy Policy P3 - Minimum Necessary, entire document • UHG Privacy Policy Manual, section 1.400-1.440, pages 3 through 6 and section 2.21-2.22, pages 9 and 10 **Additional Evidence:** • UHC Safe & Secure With Me – Information Privacy_2024 Training Content (identified in virtual review)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The plan has policies and procedures in place to ensure when requesting or receiving information to or from covered entities or business associates, PHI is limited to the minimum necessary. Although UHC provides furnishes other covered entities with		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
access to member PHI as necessary, the nature of those requests, often handled through the use of web portals and APIs, do not lend themselves to easy documentation other than through the use of file logs and UHC did not locate any such requests from previous MCEs (or otherwise) during the relevant time period. Notwithstanding, this UHC has robust protections to limit the disclosure of PHI to the minimum necessary to accomplish the intended purpose of a use, disclosure or request, as more set forth in the other attached evidence.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. Minimum necessary does not apply to: a. Disclosures to or requests by a health care provider for treatment. b. Uses or disclosures made to the individual. c. Uses or disclosures made pursuant to an authorization under 42 CFR §164.508. d. Disclosures made to the Secretary regarding compliance and investigations under 45 CFR Part 160. e. Uses or disclosures that are required by law as described in 45 CFR §164.512(a). f. Uses or disclosures that are required for compliance with applicable requirements of 45 CFR §164.502. 45 CFR §164.502(b)(2) 45 CFR §164.508 45 CFR §164.512(a) 45 CFR Part 160 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • UHC Privacy Policy P3 - Minimum Necessary, entire document • UHG Privacy Policy Manual section 1.400-1.440, pages 3 through 6 and section 2.21-2.22, pages 9 and 10 • UHC Safe & Secure With Me – Information Privacy_2024 Training Content • UHC Safe & Secure With Me – Information Privacy & Health Care Fraud, Waste and Abuse and Code of Conduct _2024 Annual Training Attestations	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The plan has policies and procedures in place to ensure when requesting or receiving information to or from covered entities or business associates, PHI is limited to the minimum necessary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Use and Disclosures Requiring Authorizations		
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. a. If a covered entity seeks an authorization from an individual for a use or disclosure of PHI, the covered entity provides the individual with a copy of the signed authorization. 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 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Authorization for use and disclosure form template • Two examples of signed authorizations for the purposes outlined in 45 CFR §164.508 **Evidence as Submitted by the MCE:** • HIPAA Guidelines for All Callers_Member Services (All pages) • UHC Privacy Policy P2 - UHC Identification and Authentication Policy, procedure section A.2.g, page 2 • UHC Privacy Policy P14 – Authorizations, entire document • UHG Privacy Policy Manual, sections 2.100-2.1130, pages 10 through 28 • ROI - UHC Authorization for Release of Information Instructions	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• ROI - UHC Authorization for Release of Information • HIPAA C&S Louisiana, Authorized Representative Section, page 2. **Additional Documentation:** • They didn't have any examples -virtual	
MCE Description of Process: In LA, LDH manages the authorized representative process so the plan would not have authorized representative forms from members. If a member wishes to give access to their PHI to another party, the member must file that request with LDH. Information from LDH is communicated to the plan on the 834-enrollment file. Member Services Advocate will verify a call's status as an appointed representative with LDH prior to providing any PHI.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Privacy Rights		
10. The MCE complies with the member's right to request privacy protection for PHI and the requirements under 45 CFR §164.522. 45 CFR §164.522 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for privacy protection • Two examples of member's request for privacy protection, including documentation of the request and evidence to support completion of the privacy protection request	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • HIPPA Job-Aid Member Services (entire document) • EQRO Integrated Member Handbook (pg.83 Your rights: To ask us to limit) • HIPAA Member Rights and Records Requests Member Services (All pages) • UHC Privacy Policy P4 – Restrictions, entire document • UHC Privacy Policy P5 - Confidential Communications, entire document • UHG Privacy Policy Manual, section 3.400-3.420 pages 33 through 35 • UHC Individual Rights Restriction Process, entire document, entire document	
MCE Description of Process: UnitedHealthcare Community Plan adheres to the privacy protection requirements outlined in 45 CFR §164.522 by training staff through HIPAA-compliant job aids that guide the handling of member requests for restrictions and confidential communications. These privacy rights, including the member's right to request limits on the use and disclosure of their Protected Health Information (PHI), are also clearly outlined in the Member Handbook to ensure members are informed and empowered to exercise their rights. When a member requests restrictions or changes to the release of their PHI, Member Services Advocates follow the process outlined in the Confidential Communications section of the HIPAA Member Rights and Records Requests Member Services SOP. The Advocate follows the outlined steps to process the request. The member is then advised that all requests must be submitted in writing and that they will be mailed a form to complete from the Member Individual Rights Request Department. The completed form is processed upon receipt. UHC was unable to identify examples of plan members' request for privacy protection during the relevant time period; however, the other documentary evidence provided demonstrates UHC's compliance with 45 CFR §164.522.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
11. The MCE complies with the member's right to access PHI and the requirements under 45 CFR §164.524. a. The MCE acts on a request for access no later than 30 days after receipt of the request. 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. 45 CFR §164.524 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to access PHI • 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 **Evidence as Submitted by the MCE:** • EQRO Integrated Member Handbook (pg.83 Your rights: To ask to get confidential communications) • Care Management and National New Hire Training (screenshot) • HIPAA Member Rights and Records Requests Member Services, Access to PHI section, page 1 and PHI Access, Amendments or Restrictions section, pages 3 and 4 • Member Rights and Responsibilities Member Services (All pages) • UHC Privacy Policy P6 - Right to Inspect and Obtain Copy of DRS, entire document • UHC Individual Rights Access Process, entire document • UHC Member PHI Access Request Form • UHG Privacy Policy Manual, section 5.00, section 5.00 through 5.300, pages 39 through 42.	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare Community Plan complies with members' rights to access their Protected Health Information (PHI) in accordance with applicable regulations. The rights and procedures for requesting access are outlined in the Member Handbook to ensure transparency and member awareness. Staff are thoroughly trained on the handbook's contents, including member rights and responsibilities. When a member requests access to their PHI, Member Services Advocates will follow the steps outlined in the PHI Access, Amendments or Restrictions section of the HIPAA Member Rights and Records Requests Member Services SOP. The SOP provides step by step instructions for the Advocate to process the request, offers an address if the member wishes to mail in the request and to educate the member that their request will be processed by the Privacy Office within 30 days of receipt. UHC was unable to identify examples of plan members' request to access PHI during the relevant time period; however, the other documentary evidence provided demonstrates UHC's compliance with 45 CFR §164.524.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE develop a mechanism for documenting and tracking all protected health information (PHI)-related requests.		
Required Actions: No action required.		
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. • The MCE acts on the member's request for an amendment no later than 60 days after receipt of such a request. 45 CFR §164.526 42 CFR §457.1110(e) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form to amend PHI • Two examples of member's request to amend PHI, including documentation of the request and evidence to support timely completion of the amendment request • One example of a denial of an amendment and notification to the member	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • EQRO Integrated Member Handbook (pg.84 Your rights: To ask to amend) • Integrated New Member Insert (pg.9 Other plan details: Request medical records) • Care Management and National New Hire Training (screenshot) • HIPAA Member Rights and Records Requests Member Services, Request Amendments to PHI section, page 2 and PHI Access, Amendments or Restrictions section, pages 3 and 4 • Member Rights and Responsibilities Member Services (All pages) • UHC Privacy Policy P7 - Right to Request an Amendment, entire document • UHC Individual Rights Amendment Process, entire document • UHG Privacy Policy Manual, section 5.400 through 5.470, pages 42 through 45	
MCE Description of Process: UnitedHealthcare Community Plan complies with members' rights to amend their record or Protected Health Information (PHI) in accordance with applicable regulations. The rights and process for requesting an amendment are outlined in Member materials like handbooks, welcome letters, etc., to ensure transparency and member awareness. When a member is requesting an amendment to their PHI, Member Services Advocates follow the steps outlined in the PHI Access, Amendments or Restrictions section of the HIPAA Member Rights and Records Requests Member Services SOP. The SOP provides step by step instructions for the Advocate to request the change as well as educating the member that their request will be processed by the Privacy Office within 30 days of receipt. An address is also provided for cases where the member wishes to mail in their request. UHC was unable to identify examples of plan members' request to amend PHI during the relevant time period; however, the other documentary evidence provided demonstrates UHC has policies and procedures in place to		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
document member requests to amend PHI, and to complete or deny such request in a timely matter, with notice to the member as necessary, as required pursuant to 45 CFR §164.526.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. a. The MCE acts on the member's request for an accounting, no later than 60 days after receipt of such a request. b. The MCE documents the accounting of disclosures and retains the documentation as required by 45 CFR §164.530(j). 45 CFR §164.528 45 CFR §164.530(j) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • Process workflow • Member request form for an accounting of disclosures of PHI • Mechanism to track disclosures (e.g., where reports to Adult Protective Services are documented within the system for retrieval for the accounting of disclosure) • 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 • Documentation to demonstrate how the record of the accounting of disclosures is retained **Evidence as Submitted by the MCE:** • EQRO Integrated Member Handbook (pg. 84 Other plan details: To get an accounting) • Care Management and National New Hire Training (screenshot)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• HIPAA Member Rights and Records Requests Member Services, Receive an Accounting section, page 1 and PHI Disclosure section pages 2 and 3 • Member Rights and Responsibilities Member Services (All pages) • UHC Privacy Policy P8 - Accounting of Disclosures, entire document • UHC Individual Rights Accounting Process, entire document • UHG Privacy Policy Manual, section 7.00 through 7.800, pages 45 through 48 • UHC Enterprise Privacy Incident Submission Form • UHC Radar Assessment Tab Example_Redacted	
MCE Description of Process: UnitedHealthcare Community Plan complies with members' rights to obtain an accounting of when their record or Protected Health Information (PHI) is shared in accordance with applicable regulations. The process for requesting such information is outlined in the Member handbook to ensure transparency and member awareness. When a member requests an accounting of their PHI disclosures, Member Services Advocates follow the process outlined in the PHI Disclosures or Copy of the Notice of Privacy Practices section of the HIPAA Member Rights and Records Requests Member Services SOP. This document provides step by step directions to complete the request as well as provide education to the member that their request will be processed by the Privacy Office within 30 days of receipt. An address is also provided for cases where the member wishes to mail in their request. UHC was unable to identify examples of plan members' request for accounting of disclosures relevant time period; however, the other documentary evidence provided demonstrates UHC has policies and procedures in place to document and support timely completion such requests, as required by 45 CFR §164.528.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
Breach of Unsecured PHI		
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. a. Breach and unsecured PHI are as defined in 45 CFR §164.402. 45 CFR §164.402 45 CFR §164.404(a)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • 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 **Evidence as Submitted by the MCE:** • EQRO Integrated Member Handbook (Health Plan Notices of Privacy Practices pg. 81) • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • UHC Enterprise Privacy Incident Submission Form • UHC Radar Assessment Tab Example_Redacted • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 - 6 • UHC Template Member Breach Notification Letter	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare Community Plan communicates breach notification procedures through the Notice of Privacy Practices, which is embedded in the Member Handbook. In addition, we maintain proactive processes for identifying and tracking potential risks		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
or incidents using a risk assessment tool. The plan has policies and procedures in place to notify members of discovery of a breach of unsecured PHI. UHC did not identify a breach specifically impacting the Plan during the relevant time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 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. 45 CFR §164.404(a) 45 CFR §164.406(a) 45 CFR §164.408(a) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Incident risk assessment tool • Unauthorized disclosure/breach tracking mechanism • List of all breaches of unsecured PHI during the time period under review, including the date of discovery **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management • UHC Enterprise Privacy Incident Submission Form • UHC Radar Assessment Tab Example_Redacted • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 - 6 • UHG_Enterprise Incident Management Reporting and Response Policy • UHG Privacy Policy Manual, section 10.00, pages 49-50	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The plan has breach notification processes and tracking systems. UHC did not identify a breach specifically impacting the Plan during the relevant time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 45 CFR §164.404(b) 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • List of all breaches of unsecured PHI during the time period under review, including the date of discovery and date of notification to members • Three examples of breach notification letters to members **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section, A,B and C, page 1 and Procedure section A.2.c, page 2 • UHC Enterprise Privacy Incident Submission Form • UHC Radar Assessment Tab Example_Redacted • HIPAA-HITECH Act Breach Notification Rule • UHG_Enterprise Incident Management, section Notification to affected individuals pgs. 5 - 6 Reporting and Response Policy • UHG Privacy Policy Manual, section 10.00, pages 49-50	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The plan has breach notification processes and tracking systems. UHC did not identify a breach specifically impacting the Plan during the relevant time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The notification (to individuals, and to media outlets, if required) must be written in plain language and include, to the extent possible: a. A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known. 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). c. Any steps individuals should take to protect themselves from potential harm resulting from the breach. 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. 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. 45 CFR §164.404(c) 45 CFR §164.406(c) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Breach notification letter template • Reading grade level of breach notification letter template • Three examples of breach notification letters to members • One example of notification to media outlet, if applicable during the review period **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 – 6, • UHC Template Member Breach Notification Letter • UHC Member Breach Notification_4.6 Reading Level	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The plan has breach notification processes and tracking systems. UHC did not identify a breach specifically impacting the Plan during the relevant time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Privacy Policy P19—Privacy Complaint and Incident Management to be inclusive of all requirements.		
Required Actions: No action required.		
18. The notification must be provided in the following form: 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. 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. c. The notification may be provided in one or more mailings as information is available. 45 CFR §164.404(d)(1) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Confirmation of first-class mailing **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 – 6, • UHC Template Member Breach Notification Letter • UHC First Class Mailing Envelope	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare has established policies and procedures to guide the preparation and distribution of member notifications, including breach-related communications.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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. 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. b. If there is insufficient or out-of-date contact information for 10 or more individuals, then such substitute notice must: 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. 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. 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). 45 CFR §164.404(d)(1)(ii) 45 CFR §164.404(d)(2) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • 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 • 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 **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 - 6	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare has established policies and procedures to address situations involving insufficient or outdated contact information when issuing written breach notifications. UHC did not identify a breach specifically impacting the Plan during the relevant time period that would give rise to substitute notice pursuant to 45 CFR §164.404(d)(2).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Privacy Policy P19—Privacy Complaint and Incident Management to be inclusive of all requirements.		
Required Actions: No action required.		
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). 45 CFR §164.404(d)(1) 45 CFR §164.404(d)(3) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • One example of notice provided to members for an urgent situation, if applicable during the review period **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • HIPAA-HITECH Act Breach Notification Rule, section Notification to affected individuals pgs. 5 - 6	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare has implemented policies and procedures to manage situations where contact information for impacted individuals is insufficient or outdated during breach notification efforts. UHC did not identify a breach specifically impacting the Plan during the relevant time period that would give rise urgent notification pursuant to 45 CFR §164.404(d)(3).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Privacy Policy P19—Privacy Complaint and Incident Management to be inclusive of all requirements.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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. 45 CFR §164.404(c) 45 CFR §164.406(a-b) MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • 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 **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • HIPAA-HITECH Act Breach Notification Rule, section Notification to the Media, page 7	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare has established policies and procedures to ensure timely and compliant notification to media outlets in the event of a breach affecting a large number of individuals. UHC did not identify a breach specifically impacting the Plan during the relevant time period that would give rise to media notice pursuant to 45 CFR §164.406.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Privacy Policy P19—Privacy Complaint and Incident Management to be inclusive of all requirements.		
Required Actions: No action required.		
22. The MCE must, following the discovery of a breach of unsecured PHI, notify the Secretary. 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	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI, including whether the breach involved 500 or more members or less than 500 members	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
contemporaneously with the notice required by 45 CFR §164.404(a) and in the manner specified on the Department of Health and Human Services (HHS) Web site. 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. 45 CFR §164.404(a) 45 CFR §164.408 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	• Annual notification to HHS of breaches of unsecured PHI, including the date of notification **Evidence as Submitted by the MCE:** • UHC Privacy Policy P19 - Privacy Complaint and Incident Management, policy section A,B and C, page 1 and Procedure section A.2.c, page 2 • UHC Enterprise Privacy Incident Submission Form • UHC Radar Assessment Tab Example_Redacted • HIPAA-HITECH Act Breach Notification Rule, section Notification to the Secretary section, page 4 • HHS Submitting Notice of a Breach to the Secretary • HHS OCR Breach Report Template • HHS Sample Report	
MCE Description of Process: UnitedHealthcare has established comprehensive policies and procedures to guide all aspects of breach notification. These protocols ensure timely identification, assessment, and communication of privacy incidents in accordance with applicable federal and state regulations. UHC did not identify a breach specifically impacting the Plan during the relevant time period that would require notification to the Secretary; however, our policies demonstrate the procedure UHC employs to make any such required notifications.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE revise the Privacy Policy P19—Privacy Complaint and Incident Management to be inclusive of all requirements.		
Required Actions: No action required.		

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
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. 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. 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. 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. 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. 45 CFR §164.404(c)	**HSAG Required Evidence:** • Policies and procedures • List of breaches of unsecured PHI reported by subcontractors • One example of executed business associate agreement • One example of executed subcontractor contract **Evidence as Submitted by the MCE:** • UHC Privacy Policy P22 - Business Associate Contracting, procedure section C, pages 2 and 3 • Care Angel Master Services Agreement, Exhibit C, page 31 **Additional Documentation:** • BAA Template	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
45 CFR §164.410 45 CFR §164.412 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum		
MCE Description of Process: UnitedHealthcare has established comprehensive policies and procedures to guide breach notification efforts in accordance with federal and state regulations. These protocols ensure timely identification, assessment, and communication of privacy incidents involving member information. In addition, business associates and contractors are contractually required to notify UnitedHealthcare and those impacted promptly of any breaches, enabling coordinated and timely response efforts to protect member privacy and maintain regulatory compliance. UHC did not identify a breach specifically impacting the Plan reported by subcontractors during the relevant time period.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Privacy Practices		
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. 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). b. The MCE makes the notice available to its members on request as required by 45 CFR §164.520(c). 45 CFR §164.520(a)(1) 45 CFR §164.520(b)(1) 45 CFR §164.520(c) 42 CFR §457.1110 MCO Contract: HIPAA Business Associate Provisions PAHP Contract: HIPAA Business Associate Addendum PIHP Contract: HIPAA Business Associate Addendum	**HSAG Required Evidence:** • Policies and procedures • Process for disseminating Notice of Privacy Practices • Staff training materials • Copy of Notice of Privacy Practices • Link to Notice of Privacy Practices on the MCE's website **Evidence as Submitted by the MCE:** • EQRO Integrated Member Handbook (Health Plan Notices of Privacy) • Care Management and National New Hire Training (screenshot)	☒ Met ☐ Not Met ☐ NA

Standard II—Member Rights and Confidentiality		
Requirement	**Supporting Documentation**	**Score**
	• Copy of Notice of Privacy Practices • UHC Privacy Policy P1 - Notice of Privacy Practices, entire document **Additional Documentation:** • https://www.uhc.com/privacy	
MCE Description of Process: UnitedHealthcare meets this standard by informing members about their privacy rights and how their health information may be used or shared. We do this through the Member Handbook, our website, the Notice of Privacy Practices, and staff training to ensure consistent communication and understanding.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard II—Member Rights and Confidentiality							
Total	Met	=	24	X	1	=	24
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	24	**Total Score**		=	24

Total Score ÷ Total Applicable	=	**100%**

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. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68 • Integrated Member Insert/Welcome Letter Pg. 8 • UHC Provider Manual **Additional Documentation:** • Interpreter_Services_ULG – All Pages • Interpreter_Services_TTY_TRS_VRS – All pages • Alternate_Lang_Format_Mbr_Serv_SOP – All pages • Mbr_Material_Req_Mbr_Serv_SOP – All pages • Community Plan Handbook Training_v.2 **MCE Description of Process:** If the member has limited English proficiency or requires auxiliary aids, Member Service Advocates (MSAs) are able to connect them with an interpreter or the TTY line upon request. MSAs utilize the Member Materials Request for Alternate Language or Alternat Format Standard Operating Procedure (SOP) to send member materials in alternative formats and/or alternative languages.	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(ii) 42 CFR §457.1220	2. Be treated with respect and with due consideration for his or her dignity and privacy. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.3	• Provider Handbook • Member Rights and Responsibilities Job-aid Process and Procedure (entire document) **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP– All pages • Quality_Oversight – All pages • Community Plan Handbook Training_v.2 **MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes ensuring members are treated with respect and dignity. To uphold these standards, MSAs are audited through *Quality_Oversight* which evaluates their calls to confirm that members are treated with care, concern and respect , and that their issues are resolved appropriately.	
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68 **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP– All pages • Community Plan Handbook Training_v.2 **MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes ensuring members receive information about health care and treatment options (regardless of cost or benefit coverage).	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
42 CFR §438.100(b)(2)(iv) 42 CFR §457.1220 MCO Contract: 2.9.32. 1.4; 2.13.6.2.6; MCO Manual PAHP Contract: 2.6.9.5.1.4 PIHP Contract: 5.13.1.1.6	4. Participate in decisions regarding his or her health care, including the right to refuse treatment. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68 **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP– All pages **MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes supporting members in participating in decisions about their health care, including their right to refuse treatment.	Y ☒ N ☐ NA ☐
42 CFR §438.100(b)(2)(v) 42 CFR §457.1220 MCO Contract: 2.13.6.2.6; MCO Manual PAHP Contract: None PIHP Contract: 5.13.1.1.7	5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68 • UHC Provider Handbook Pg. 80 **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP– All pages **MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes supporting members in exercising their rights freely and without 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 ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 80 • Integrated New Member Insert/Welcome Letter Pg. 9 **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP– All pages • HIPAA_Mbr_Rights_Records_Requests_SOP – All pages **MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes requests to receive a copy of their medical records. When a member requests restrictions or changes to the release of their PHI, MSAs follow the process outlined in the *HIPAA Member Rights and Records Requests_Member Services SOP*. MSAs inform the members that all requests must be submitted in writing and advise that a form will be mailed to them by the Member Individual Rights Request Department. Once the completed form is received, the request is processed accordingly.	Y ☒ N ☐ NA ☐
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	7. Be furnished health care services in accordance with 42 CFR §438.206 through §438.210. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg 68 • UHC Provider Handbook **Additional Documentation:** • Mbr_Rights_Responsibilities_Mbr_Serv_SOP.docx	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
PIHP Contract: 5.13.1.1.14	**MCE Description of Process:** MSAs are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes the right to be furnished health care services in accordance with §§438.206 through 438.210.	
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 68 **Additional Documentation:** • Integrated Member Insert Pg. 8 • Mbr_Rights_Responsibilities_Mbr_Serv_SOP.docx **MCE Description of Process:** Member Service Advocates (MSAs) are provided with the *Member Rights and Responsibilities_Member Services SOP,* which outlines how to respond to member inquiries regarding their rights. This includes that the exercise of these rights will not be adversely affected by UnitedHealthcare, network providers, or the State in any manner.	Y ☒ N ☐ NA ☐
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	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). **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg.87	Y ☒ N ☐ NA ☐

Standard II—Member Rights Checklist		
Reference	**Required Components**	
ACA, Section 1557 MCO Contract: 2.13.6.2.6; 6.6.1 PAHP Contract: 6.4 PIHP Contract: 20.3.1	**Additional Documentation:** • Integrated Member Insert Pg. 8 • Std_II_Item_9_Grievance Handling_Discrimination_Allegations 1.docx **MCE Description of Process:** UnitedHealthcare complies with applicable federal and state laws including and provides training to staff. Grievance Handling_Discrimination_Allegations 1.docx outlines how handle and respond to discrimination practices and allegations. In addition, we also provide information on federal and state guidelines related to 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) in our member handbooks and member inserts.	

Standard III—Member Information

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Information Requirements		
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. *"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.* *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.* 42 CFR §438.10(c)(1) 42 CFR §457.1207 MCO Contract: 2.13.15 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.8.4.5	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook, provider directory, member notices, etc. • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Proof of website accessibility (e.g., assessment or testing of accessibility features of website and confirmation of 508 compliance) **Evidence as Submitted by the MCE:** • EQRO 2025- UHC Marketing Enrollee Education PP (pg. 23,30) • EQRO 2025-_Integrated Member Handbook **Additional Documentation:** • 10_28_2024_MyUHC C&S Portal VPAT 2.5 Rev508 WCAG 2.2 AA Standard 3 Element 1 (entire document) Secure portal (myuhc.com) • UHCCP Louisiana Public Site VPAT 2.5 Rev508 WCAG 2.1 AA 2025-06-24 FINAL REVIEW (entire document) non-secure portal (uhccp.com)	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• UHC Member Handbook 2024.pdf • Our team identified errors and have a plan to address the errors. – Accessibility Center of Excellence Q1 2025.pdf	
MCE Description of Process: UnitedHealthcare supports accessibility standards by implementing formal policies and procedures that promote inclusive access to information and services. This includes conducting regular website accessibility assessments to ensure digital content meets usability standards and maintaining accessible online member handbooks that are easy to navigate and compliant with accessibility guidelines.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. HSAG utilized the web accessibility evaluation tool (WAVE) to assess website accessibility of UHC's landing homepage and "find a provider" landing page. The results of both tests identified broken accessible internet rich applications (ARIA) reference errors.		
Required Actions: 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.		
2. The MCE uses the definitions for managed care terminology developed by the State including: 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. 42 CFR §438.10(c)(4)(i)	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • EQRO 2025-_Integrated Member Handbook (Physical health benefits covered by UnitedHealthcare Community Plan Pg 28-38) **Additional Documentation:** • UHC Member Handbook 2024.pdf	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1207 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary		
MCE Description of Process: UnitedHealthcare Community Plan uses state-developed terminology in member materials, including handbooks to ensure clarity, consistency, and alignment with state guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE uses State-developed model member handbooks and member notices. PIHP: a. *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.* 42 CFR §438.10(c)(4)(ii) 42 CFR §457.1207 MCO Contract: 2.13.6.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.1	**HSAG Required Evidence:** • Policies and Procedures • Member materials, such as the member handbook • Member notice templates, such as adverse benefit determination (ABD) notices, grievance and appeal notices (include any other template for all State-required model notices) **Evidence as Submitted by the MCE:** • EQRO 2025-_Integrated Member Handbook (Entire handbook Pg. 70,75,77,79) • EQRO 2025- UHC Marketing Enrollee Education PP (Pg. 9) • UHCCP LA Partial Denial NOA Template • UHCCP LA NOA Template III 3 • UHCCP LA CAID NOA PDHC MMBPRV Template • UHCCP LA CHISHOLM MIOD Template III 3	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Developed member handbooks, notices, and policies by integrating state-specific recommendations and aligning with a guided state handbook model.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Language and Format		
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. 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. 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. c. Written materials that are critical to obtaining services include information on how to request auxiliary aids and services. 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. e. Auxiliary aids and services must be made available upon request of the member or potential member at no cost.	**HSAG Required Evidence:** • Policies and procedures • Provider directory in English, including taglines • Provider directory in prevalent non-English languages, including taglines • Member handbook in English, including taglines • Member handbook in prevalent non-English languages, including taglines • Examples of member notices in English, including taglines (i.e., appeal, grievances, and ABD notices) • Examples of member notices in prevalent non-English languages (i.e., appeal, grievances, and ABD notices), including taglines • Definition of conspicuously visible font • Mechanisms to ensure taglines are included as part of all critical member materials **Evidence as Submitted by the MCE:** • EQRO 2025- UHC Marketing Enrollee Education PP (Pg. 12, 22, 23,31)	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.10(d)(3) 42 CFR §457.1207 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	• EQRO 2025-_Integrated Member Handbook (Pg. 60,87-88) • UHC Spanish EQRO 2025-_Integrated Member Handbook (Entire Book) **Additional Documentation:** • UHC Member Handbook 2024.pdf page 87-88	
MCE Description of Process: Written materials are made accessible in alternative formats and in the most prevalent non-English languages spoken in the state, adhering to required font size standards. All materials include clear instructions for requesting auxiliary aids and services, including toll-free and Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) contact options, in full compliance with state accessibility requirements.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The written material reviewed by HSAG did not include a tagline in the prevalent non-English language that was in a conspicuous font.		
Required Actions: The MCE must include a tagline for all written materials that are critical to obtaining services. The tagline must be in the prevalent non-English languages and in a conspicuously visible font size explaining the availability of written translation or oral interpretation to understand the information provided.		
5. The MCE makes interpretation services available to each member free of charge. a. This includes oral interpretation and the use of auxiliary aids such as TTY/TDD and American Sign Language (ASL). b. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. 42 CFR §438.10(d)(4) 42 CFR §457.1207	**HSAG Required Evidence:** • Policies and procedures • Executed interpretation services (oral and written) contract(s) • Workflow for obtaining oral interpretation services **Evidence as Submitted by the MCE:** • UHC_Interpreter Services SOP_Mbr_Serv; All Pages	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
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	• UHC_Interpreter_Serv_ULG_SOP_Mbr_Serv; All Pages • UHC_In-Office_Interpreter_SOP_Mbr Serv; All Pages • EQRO 2025- UHC Marketing Enrollee Education PP (pg.22) • EQRO 2025-_Integrated Member Handbook (Pg. 60,87)	
MCE Description of Process: Interpretation services are available in multiple formats—including written, oral, auxiliary aids, and American Sign Language (ASL). Member Service Advocates (MSAs) follow detailed Standard Operating Procedures (SOPs) to ensure free interpretation support is provided to individuals with limited English proficiency, including access to TRS/TTY, in-office interpreters, and ASL services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE notifies members: a. That oral interpretation is available for any language and written translation is available in prevalent languages; b. That auxiliary aids and services are available upon request and at no cost for members with disabilities; and c. How to access these services. 42 CFR §438.10(d)(5) 42 CFR §457.1207 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • EQRO 2025- UHC Marketing Enrollee Education PP (pg.22) • EQRO 2025-_Integrated Member Handbook (Pg. 60, 87) **Additional Documentation:** • UHC Member Handbook 2024.pdf	☐ Met ☒ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Policies and procedures are in place to ensure members are informed of the availability of free interpretation services—covering all languages, oral and written communication, and auxiliary aids. This information is clearly outlined in member materials, with guidance on how to request services at no cost.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted as evidence did not verify compliance with the requirements. Although the member handbook included language that stated UHC can provide translated printed materials if the member speaks a language other than English, the verbiage was not specific as to written translation being available in prevalent languages.		
Required Actions: The MCE must notify members that written translation is available in prevalent languages.		
7. The MCE provides all written materials for potential members and members consistent with the following: a. Use easily understood language and format. b. Use a font size no smaller than 12 point. c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members or potential members with disabilities or limited English proficiency. *"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.* 42 CFR §438.10(d)(6) 42 CFR §457.1207 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	**HSAG Required Evidence:** • Policies and procedures • Member handbook • Provider directory • All member newsletters during the time period of review • Member notices (in Microsoft Word), including an ABD notice, grievance resolution notice, and appeal resolution notice • Mechanism to assess reading grade level of member materials and supporting evidence (e.g., screenshots of reading grade level of member materials) • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services • Tracking or reporting mechanism on use of interpretation services and auxiliary aids and services	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • UHC_Alternate_Lang_Format_Mbr_Serv_SOP: All Pages • UHC_Mbr_Material_Req_Mbr_Serv_SOP; All Pages • EQRO 2025- UHC Marketing Enrollee Education PP (pg.22, 30) • EQRO 2025-_Integrated Member Handbook (Pg. 12, 60, 87) • Provider Directory December 2024 (entire document)	
MCE Description of Process: Our health plan ensures that all written materials for members and potential members are provided in a clear, easy-to-understand format, using a font size no smaller than 12-point. Materials are available in alternative formats and with auxiliary aids and services at no cost, accommodating individuals with disabilities or limited English proficiency. Member Service Advocates (MSAs) follow established Standard Operating Procedures to fulfill requests for materials in alternate languages or formats		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information for Members		
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: a. Thirty calendar days prior to the effective date of the termination; or	**HSAG Required Evidence:** • Policies and procedures • Workflow of provider termination process • Two examples of MCE-initiated provider terminations, including evidence of the effective date of the termination and the notice sent to affected members	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
b. Fifteen calendar days after receipt or issuance of the termination notice. PAHP: 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. 42 CFR §438.10(f)(1) 42 CFR §457.1207 MCO Contract: 2.13.9.2 PAHP Contract:2.6.11.4 PIHP Contract: 5.14.1.2	• 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 • Two examples of provider-initiated terminations when the effective date of the termination has passed (i.e., retroactive termination), including evidence of the notification date from the provider (e.g., letter, email) and the notice sent to affected members • Tracking or reporting mechanism that demonstrates timeliness	
	• E2E Termination Process.PDF • ET-03 Potential and Actual Provider Term Policy.PDF • Member Notification of Provider Term Samples.docx • Provider Term Member Notice Mailing Rule.docx • Member Notification Dashboard_Narrative.docx	
MCE Description of Process: UnitedHealthcare makes every effort to notify members of a provider termination in a timely manner. We have policies and procedures in place to ensure timeliness of each step in the process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
9. The MCE makes available upon request, any physician incentive plans in place as set forth in 42 CFR §438.3(i). 42 CFR §438.3(i) 42 CFR §438.10(f)(3) 42 CFR §457.1207 MCO Contract: 2.17.4.5 PAHP Contract: None PIHP Contract: 20.41.1	**HSAG Required Evidence:** • Policies and procedures • List of physician incentive plans • 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 *MCE Description of Process*) **Evidence as Submitted by the MCE:** • EQRO 2025- UHC Marketing Enrollee Education PP (pg.12) • EQRO 2025-_Integrated Member Handbook pg.65 • CY24 VBP Year-End Report UHC 20250317	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: We have established processes to provide physician incentive plans upon request, ensuring transparency and compliance with applicable guidelines.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Member Handbook		
10. The member handbook is provided to the member within a reasonable time frame. The member handbook is considered provided if the MCE: a. Mails a printed copy of the information to the member's mailing address;	**HSAG Required Evidence:** • Policies and procedures • Mechanism for disseminating the member handbook (e.g., mailing of printed copy, mailing of welcome packet with link to member handbook on website, etc.)	☒ Met ☐ Not Met ☐ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
b. Provides the information by email after obtaining the member's agreement to receive the information by email; 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 d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. PAHP: a. The PAHP shall furnish the following materials within ten (10) business days following receipt of the member file to each person who is newly enrolled or re-enrolled: i. A current enrollee handbook 42 CFR §438.10(g)(1) 42 CFR §438.10(g)(3) 42 CFR §457.1207 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	• Member materials, such as member welcome packet • Tracking mechanism for mailings of the member handbook or welcome notice, and the date of the notice to the member **Evidence as Submitted by the MCE:** • UHC_ LA_Resources_Mbr_Serv_Job_Aid; (Pg.1) • UHC_Mbr_Material_Req_Mbr_Serv_SOP; all pages • EQRO 2025- UHC Marketing Enrollee Education PP (pg. 6-7) • EQRO 2025 CSG11908781 Eng LA Integrated New Member Insert • LA_Orientation of Member Materials_v.01.01.24 • LA Audit Tracking mechanism Reporting_2024 **Additional Documentation:** • EQRO 2025- CSG11908781_Eng_LA_Integrated _NewMember+Insert-.pdf	
MCE Description of Process: We have established processes and tracking mechanisms to ensure the timely and accurate delivery of member materials. Member Service Advocates (MSAs) are available to assist members in obtaining a copy of their handbook, either through the online plan website or by requesting a printed copy to be mailed to their address.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: Although UHC's new member insert included information on the availability of the member handbook via registration at myUHC.com/community plan, HSAG recommends that UHC consider adding language to the new member insert that informs the member of the availability of the member handbook on the website, to include applicable internet address.		
Required Actions: No action required.		
11. The member handbook includes all requirements listed in the Member Handbook Checklist. 42 CFR §438.10(g)(2) 42 CFR §457.1207 MCO Contract: 2.13.6.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Searchable (Word/PDF) version of member handbook (version that would be provided to member if paper copy requested) • Link to member handbook on MCE's website • HSAG will also use the results of the Member Handbook Checklist **Evidence as Submitted by the MCE:** • LA Integrated Handbook (Entire document) • Member Handbook Checklist • EQRO 2025- UHC Marketing Enrollee Education PP (pg. 9-12) **Additional Documentation:** • UHC Member Handbook 2024.pdf	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Our member handbooks are developed in alignment with state guidelines and standardized handbook models to ensure consistency, clarity, and compliance. They are designed to meet regulatory requirements for content, accessibility, and formatting, supporting clear communication with all members		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's member handbook did not include information regarding specialized behavioral health services specific to: • Description of the family/caregiver of 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. • Age(s) of consent for behavioral health treatment as per 42 CFR Part 2.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must include in the member handbook information regarding specialized behavioral health services specific to: • Description of the family/caregiver of 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. • Age(s) of consent for behavioral health treatment as per 42 CFR Part 2.		
12. The MCE, at least 30 days before the intended effective date of 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 the change. *Note: LA defines significant as "important in effect or meaning."* 42 CFR §438.10(g) 42 CFR §457.1207 MCO Contract: 2.13.2.3 PAHP Contract: 2.9.7.2; 2.9.8.4.1 PIHP Contract: 5.8.3.3	**HSAG Required Evidence:** • Policies and procedures • Workflow for member handbook changes • 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 *MCE Description of Process*) • Tracking mechanism for timely member notifications of significant changes that demonstrate the effective date of the significant change, and the date members were notified **Evidence as Submitted by the MCE:** • Eng_LA_Disenrollment_Handbook_Addendum • EQRO 2025- UHC Marketing Enrollee Education PP (pg. 9) • LA_Creation of Member Materials_v.01.01.24 (entire document)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Our health plan has policies and procedures in place to ensure compliance with state requirements for notifying members of any significant changes to the member handbook. Members are provided written notice of such changes—defined as significant by the state—at least 30 days prior to the intended effective date, as outlined in the member handbook.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Provider Directory		
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. 42 CFR §438.10(h)(1-2) 42 CFR §457.1207 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	**HSAG Required Evidence:** • Policies and procedures • Process for generating a paper copy of the provider directory (e.g., bulk printing, print on demand) • Copy of the member-facing provider directory in Word or PDF format (excerpts are acceptable) • Link to the online provider directory • HSAG will also use the results of the Provider Directory Checklist **Evidence as Submitted by the MCE:** • Provider Directory_Narrative.docx • C_S Provider Directory Paper Creation Policy.doc • C_S FPC Online Directory Policy.doc • Provider Directory December 2024.pdf • Member Materials - Provider Directory Requests • UHC_ Mbr_Materials_Prov_Dir_Mbr_ Serv_SOP; Pages 1-3	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Provider Network Depiction team creates an automated paper provider directory and an electronic directory utilizing the data housed in NDB (National data base). A paper directory is created for members and providers to request in lieu of using the online directory. The electronic directory is created for use by those who wish to access the directory online or via the UnitedHealthcare app. Member Service Advocates (MSAs) utilize the Member Materials - Provider Directory Requests SOP to assist members with obtaining access to their provider directory online or by printed delivery.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Recommendations: 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).		
Required Actions: No action required.		
14. Information included in the MCE's paper provider directory is updated at least: a. Monthly, if the MCE does not have a mobile-enabled electronic provider directory; or b. Quarterly, if the MCE has a mobile-enabled electronic provider directory. PAHP: a. *The PAHP shall update the printable version of the provider directory at least quarterly and include versioning.* 42 CFR §438.10(h)(3)(i) 42 CFR §457.1207 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	**HSAG Required Evidence:** • Policies and procedures • Verification of a mobile-enabled electronic provider directory • Workflow for updating paper provider directories • Three consecutive provider directory update examples, including the dates for when the updates were made **Evidence as Submitted by the MCE:** • Provider Directory Paper Directory Updates_Narrative.docx • Directory Maintenance Schedule SOP.docx • C&S Provider Directory Data Flows.pptx • Provider Directory_October 2024 • Provider Directory_November 2024 • Provider Directory December 2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Provider Network Depiction team creates an automated paper provider directory that is published monthly. The directory is created from the data housed on NDB (National Data Base). A paper directory is created for members and providers to request in lieu of using the electronic directory. Members receive a welcome letter with their member ID card upon enrollment, with information on how to access the provider directory. This information is also available in the Member Handbook and on the website.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		
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. MCO: a. The web-based online version shall be updated in real time, but no less than weekly. PAHP: 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. 42 CFR §438.10(h)(3)(ii) 42 CFR §457.1207 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	**HSAG Required Evidence:** • Policies and procedures • Workflow for updating the electronic provider directory • 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 • Tracking mechanisms to demonstrate timeliness **Evidence as Submitted by the MCE:** • Directory Maintenance Schedule SOP.docx • C&S Provider Directory Data Flows.pptx • Provider_Directory_Updates.docx	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Provider Network Depiction team creates electronic provider directories which are refreshed according to the schedules with the most current provider data available at the time of the directory data inquiry. Online directories provider demographics are live stream. UHC directories are created for use by all constituents (Member, Provider, Broker, etc)		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.10(h)(4) 42 CFR §457.1207 MCO Contract: 2.13.8.1.2 PAHP Contract: 2.9.2.1.1 PIHP Contract: 5.10.1	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable provider directory (e.g., .JSON format) • Link to the publicly available machine-readable provider directory on the MCE's website **Evidence as Submitted by the MCE:** • Provider Directory Machine Readable_Narrative.docx • Machine Readable Files Access_SOP.docx	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Provider Network Depiction team creates Machine Readable directories which are updated monthly and posted to the UHC website for access by all who prefer utilizing this method to access directory information.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Formulary		
17. The MCE makes available in electronic or paper form the following information about its formulary: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. 42 CFR §438.10(i)(1-2) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: NA.	**HSAG Required Evidence:** • Policies and procedures • Copy of formulary in Word or PDF format (excerpts are acceptable) • Link to the publicly available formulary on the MCE's website **Evidence as Submitted by the MCE:** • EQRO 2025-_Integrated Member Handbook (pg. 89-94)	☐ Met ☐ Not Met ☒ NA

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
	• UHC Standard III Member Information Requirement 17 & 18 Narrative	
MCE Description of Process: Our health plan provides formulary information in both electronic and paper formats, detailing which medications are covered—including both generic and brand-name drugs—and their corresponding tier levels. Members are also provided with clear instructions on how to access this information online or request a printed copy through Member Services.		
HSAG Findings: 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.		
Required Actions: No action required.		
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. 42 CFR §438.10(i)(3) 42 CFR §457.1207 MCO Contract: 2.19.14.3 PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Confirmation of machine-readable formulary (e.g., .JSON format) • Link to the publicly available machine-readable formulary on the MCE's website **Evidence as Submitted by the MCE:** • EQRO 2025-_Integrated Member Handbook (pg. 89-94) • UHC Standard III Member Information Requirement 17 & 18 Narrative	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: A formulary drug list available on the website in a machine-readable file and format, as specified by requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard III—Member Information		
Requirement	**Supporting Documentation**	**Score**
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: a. The format is readily accessible. b. The information is placed in a location on the MCE's website that is prominent and readily accessible. c. The information is provided in an electronic form which can be electronically retained and printed. d. The information is consistent with the content and language requirements of 42 CFR §438.10. e. The member is informed that the information is available in paper form without charge upon request and provides it upon request within five business days. 42 CFR §438.10(c)(6) 42 CFR §457.1207 MCO Contract: 2.14.1.8 PAHP Contract: 2.9.2.1.1; 2.9.2.1.2.5 PIHP Contract: 5.1.14; 5.7	**HSAG Required Evidence:** • Policies and Procedures • Workflow for disseminating member materials • List of all materials that are only provided electronically • Link to the MCE's homepage of its website • 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) • Evidence for how members are informed that paper copies of information are available upon request and without charge **Evidence as Submitted by the MCE:** • EQRO 2025-_Integrated Member Handbook (pg. 89-94) • LA_Orientation of Member Materials_v.01.01.24	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: We have established processes and practices to ensure member materials are available in both electronic and paper formats, and are provided upon request to support member preferences and accessibility needs		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's website did not include language informing the member that the information that is available in electronic form is available in paper form without charge upon request and that the MCE provides it upon request within five business days.		
Required Actions: The MCE must inform members on the website that the information provided electronically is available in paper form without charge upon request and provide it upon request within five business days.		

Results for Standard III—Member Information							
Total	Met	=	13	X	1	=	13
	Not Met	=	5	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	18	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**72%**

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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 28-58	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook (throughout document)	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook Page 12, 20	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(ii)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.16 PAHP Contract: 2.9.7.2; 2.4.4.2 PIHP Contract: 5.9.2.17	4. In the case of a counseling or referral service that the MCE does not cover because of moral or religious objections, the MCE informs members that the service is not covered by the MCE. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 64	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(ii)(A-B) 42 CFR §457.1207 MCO Contract: 2.4.6.1.4 PAHP Contract: 2.9.7.2 PIHP Contract: 20.39.2.4	5. The MCE informs members how they can obtain information from the State about how to access the services not provided by the MCE because of moral or religious objections. **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 64	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iii) 42 CFR §457.1207 MCO Contract: 2.13.6.2.7 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.10	6. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. *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.* **Evidence as submitted by the MCE:** • Integrated Member Handbook Pg. 28-58	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(iv) 42 CFR §457.1207 MCO Contract: 2.13.6.2.8 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.11	7. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. *The PIHP must also include procedures for plan of care development.* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 22, 23	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14	8. The extent to which, and how, after-hours care is provided. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 21	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(v)(A) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.1 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.1	9. What constitutes an emergency medical condition and emergency services. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 24	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(B) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.2 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.2	10. The fact that prior authorization is not required for emergency services. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 23, 24	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(v)(C) 42 CFR §457.1207 MCO Contract: 2.13.6.2.11.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.14.5	11. The fact that the member has a right to use any hospital or other setting for emergency care. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 24	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(vi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.5 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.5	12. Any restrictions on the member's freedom of choice among network providers. **Evidence as submitted by the MCE:** • Integrated Member Handbook	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 22, 32	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
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). **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 54, 90	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 68	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(x) 42 CFR §457.1207 MCO Contract: 2.13.6.2.2; 2.13.6.2.4 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.4	16. The process of selecting and changing the member's primary care provider/primacy dental provider. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 15	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 72	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 70-75	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 72	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 73	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xi)(E) MCO Contract: 2.13.6.2.18.6 PAHP Contract: 2.9.7.2 PIHP Contract: 5.9.2.18.5.1; 5.9.2.18.5.2	21. The fact that, when requested by the member, benefits that the MCE seeks to reduce or terminate will continue if the member files an appeal or a request for the SFH within the timeframes specified for filing, and that the member may, consistent with State policy, be required to pay the cost of services furnished while the appeal or the SFH is pending if the final decision is adverse to the member. **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 73	Y ☒ N ☐ NA ☐
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) *The MCOs must provide a description of advance directives which includes:* *The MCO's policies related to advance directives;* *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;*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	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 *Information about where an enrollee can seek assistance in executing an advance directive and to who copies should be given.*	
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 67	
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. *For the MCO, this instruction shall be included in all versions of the Member Handbook in English and Spanish.* *For the PIHP, this instruction shall be included in all versions of the handbook in English, Spanish, and Vietnamese.*	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Integrated Member Handbook pg.87-88	
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.	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Integrated Member Handbook pg.3 and throughout handbook	
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.	Y ☒ N ☐ NA ☐
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 66	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.9 PAHP Contract: NA PIHP Contract: NA	26. *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.* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg.10-11	Y ☒ N ☐ NA ☐
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. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 63	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.21 PAHP Contract: NA PIHP Contract: NA	28. *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";* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 21	Y ☒ N ☐ NA ☐
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. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 69	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207	30. *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;*	Y ☒ N ☐ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.6.2.29 PAHP Contract: NA PIHP Contract: NA	**Evidence as submitted by the MCE:** • Integrated Member Handbook pg. pg. 62	
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. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 65	Y ☒ N ☐ NA ☐
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. *The MCOs must include the date of the last revision;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 1	Y ☒ N ☐ NA ☐
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: 2.13.6.2.37 PAHP Contract: NA PIHP Contract: NA	33. *The MCOs must include Information regarding specialized behavioral health services (SBHS), including, but not limited to:* a. *A description of covered behavioral health services;* b. *Where and how to access behavioral health services and behavioral health providers;* c. *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;* d. *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*	Y ☐ N ☒ NA ☐

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	individuals and families; and e. *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.*	
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 43-54	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.3	34. *The PIHP must include CSoC eligibility requirements;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • LA-Medicaid-Mental-Health-Substance-Handbook-EN pg. 33-34	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.7	35. *The PIHP must include Member's Bill of Rights;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • LA-Medicaid-Mental-Health-Substance-Handbook-EN pg.46	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.12	36. *The PIHP must include where to find medical necessity criteria on the Contractor's website and how to request hardcopies of medical necessity criteria;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 43-54	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA	37. *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;"*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE:	

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PAHP Contract: NA PIHP Contract: 5.9.2.20	• Integrated Member Handbook pg. 21	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.22	38. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 44-54	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.23	39. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 44-54	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.24	40. *The PIHP must include information on contacting an Integrated Medicaid Managed Care Program Plan for primary healthcare needs;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 54	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.25	41. *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;* **Evidence as submitted by the MCE:** • Integrated Member Handbook pg. 83	Y ☐ N ☐ NA ☒
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA	42. *The PIHP must include how to identify and contact the WAAs and FSO;* **Evidence as submitted by the MCE:**	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
PAHP Contract: NA PIHP Contract: 5.9.2.26	• LA-Medicaid-Mental-Health-Substance-Handbook-EN pg. 33-34	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.30	43. *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;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Integrated Member Handbook • LA-Medicaid-Mental-Health-Substance-Handbook-EN pg. 36	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.33	44. *The PIHP must include the date of the last revision;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 1 • LA-Medicaid-Mental-Health-Substance-Handbook-EN pg. 1	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.34	45. *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*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 23 • LA-Medicaid-Mental-Health-Substance-Handbook-EN pg. 21	
42 CFR §438.10(g)(2)(xvi) 42 CFR §457.1207 MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.9.2.35	46. *The PIHP must include additional information that is available upon request, including the following:* a. *Information on the structure and operation of the Contractor;* b. *Pharmacy location or medication information availability;* c. *Physician incentive plans [42 CFR §438.3(i) and 42 CFR §438.10(f)(3)]; and* d. *Service utilization policies*	Y ☐ N ☐ NA ☒

Standard III—Member Handbook Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • Integrated Member Handbook pg. 65, 89-94	

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. **Evidence as submitted by the MCE:** • Provider Directory pg. 31	Y ☒ N ☐ NA ☐
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). **Evidence as submitted by the MCE:** • Provider Directory pg. 31	Y ☒ N ☐ NA ☐
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). **Evidence as submitted by the MCE:** • Provider Directory pg. 31	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(iv) 42 CFR §457.1207	4. Website Uniform Resource Locater (URL), as appropriate. **Evidence as submitted by the MCE:** • Provider Directory pg.33	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.1		
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. **Evidence as submitted by the MCE:** • Provider Directory pg.876	Y ☒ N ☐ NA ☐
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. **Evidence as submitted by the MCE:** • Provider Directory pg. 31	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(1)(vii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1; 2.9.2.1.3.2.4 PIHP Contract: 5.10.4.1	7. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office. **Evidence as submitted by the MCE:** • Provider Directory pg.31	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
42 CFR §438.10(h)(1)(viii) 42 CFR §457.1207 MCO Contract: 2.13.8.7.2 PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: 5.10.4.3	8. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment, including but not limited to wide entries, wheelchair access, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. **Evidence as submitted by the MCE:** • Provider Directory pg.31	Y ☒ N ☐ NA ☐
42 CFR §438.10(h)(2) 42 CFR §457.1207 MCO Contract: 2.13.8.7.1 PAHP Contract: 2.6.2.7; 2.6.2.10 PIHP Contract: None	9. The MCE provider directory components are included for the following provider types: a. Physicians, including specialists; b. Hospitals; c. Pharmacies; d. Behavioral health providers; The MCO provider directory components are included for the following provider types *and shall be delineated by parish and zip code*: a. *Hospital primary care physician (PCP) groups* b. *Clinic settings* c. *Home and community-based services* d. *Outpatient therapy* e. *Residential substance use* f. *Youth residential services* g. *Inpatient mental health and residential substance use services* h. *Federally qualified health centers (FQHCs)* i. *Rural health clinics (RHCs)* j. *Child serving provider list that identifies and is available for OJJ, Department of Child and Family Services (DCFS), and LDOE field staff.* k. *Providers specializing in serving individuals with dual diagnosis of behavioral health and developmental disabilities shall be clearly identified.* l. *Providers specializing in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related and postpartum substance use disorders.*	Y ☒ N ☐ NA ☐

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
	The PAHP provider directory components are included for the following provider types: a. *Endodontists* b. *Maxillofacial surgeons* c. *Oral surgeons* d. *Orthodontists* e. *Pedodontists* f. *Periodontists* g. *Prosthodontists* h. *Special needs pedodontists*	
	Evidence as submitted by the MCE: • Provider Directory pg. 17, 23	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.1 PIHP Contract: NA	10. *The PAHP provider directory must include the following:* a. *The provider's cultural and linguistic capabilities including languages offered and whether the provider has completed cultural competence training;* b. *Office hours;* c. *Specific performance indicators;* d. *A statement that some providers may choose not to perform certain services based on religious or moral beliefs;*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Provider Directory pg. 703	
MCO Contract: NA PAHP Contract: 2.9.2.1.2.1.2 PIHP Contract: NA	11. *The PAHP Provider Directory must also include the following:* a. *Providers arranged by name in alphabetical order* b. *Showing the provider's specialty,* c. *Providers listed by specialty in alphabetical order by name.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Provider Directory pg. 31, 300,1209	

Standard II—Provider Directory Checklist		
Reference	**Required Components**	
MCO Contract: NA PAHP Contract: NA PIHP Contract: 5.10.4.2; 5.10.4.4; 5.10.4.5; 5.10.4.6	12. *The PIHP Provider Directory must include the following:* a. *Indication of populations served by the provider (e.g., age range of clients) and specialties;* b. *Identification of any restrictions on the member's freedom of choice among providers;* c. *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);* d. *Identification of providers specializing in working with members with dual diagnosis of behavioral health and developmental disabilities.*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • Provider Directory pg. 1000	

Standard IV—Emergency and Poststabilization Services

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Definitions		
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: a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. b. Serious impairment to bodily functions. c. Serious dysfunction of any bodily organ or part. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • Document Oversight and Adherence Policy Standard 1: Page 6, Emergency Medical Condition – UHC Clinical Services definition • LA New Member Insert, Page 3, Emergency Care, instructions for new members, and Page 4, Emergency Care, instructions for new members • UHC Provider Manual 2024, page 49, 1st paragraph, and page 63, 1st paragraph - instructions for providers regarding emergency services.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
2. The MCE defines "emergency services" as covered inpatient and outpatient services that are as follows: a. Furnished by a provider that is qualified to furnish these services under Title 42. b. Needed to evaluate or stabilize an emergency medical condition. 42 CFR §438.114(a) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: Part 7: Glossary and Acronyms PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • Document Oversight and Adherence Policy Standard 1: Page 6, Emergency Services – definition • LA New Member Insert, Page 3, Emergency Care, instructions for new members, and Page 4, Emergency Care, instructions for new members • UHC Provider Manual 2024, page 49, 1st paragraph, and page 63, 1st paragraph - instructions for providers regarding emergency services.	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE defines "poststabilization care services" as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, under the	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
circumstances described in 42 CFR §438.114(e), to improve or resolve the member's condition. 42 CFR §438.114(a) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 2.4.2.2 PIHP Contract: Glossary	**Evidence as Submitted by the MCE:** • Document Oversight and Adherence Policy Standard 1: Page 9, Post-Stabilization Care Services – definition • Member Handbook, top of page 26, defines coverage of Post-Stabilization services. • UHC Provider Manual 2024, page 49, last paragraph (5th) under Emergency Room Care, redefines post-stabilization services.	
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Coverage and Payment		
4. The MCE covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the MCE. 42 CFR §438.114(c)(1)(i) 42 CFR §457.1228 MCO Contract: 2.11.4.1 PAHP Contract: 2.8.3.2 PIHP Contract: 8.3.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services, with the place of service and/or other code(s) that identifies emergency services • Three case examples of a provider submitted claim for emergency services with screenshots of	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	the adjudicated claim (one example must be from an out-of-network provider)	
	Evidence as Submitted by the MCE: • LA New Member Insert, Page 3, Emergency Care, and Page 4, Emergency Care, confirms coverage of emergency services anywhere in the US and it's territories • UHC Provider Manual 2024, page 49, 1st paragraph, and page 63, 1st paragraph - instructions for providers regarding emergency services. • UHC_LA H Inpatient Authorization SOP Page 11-18 • UHC_ER Hospital Claim_ Ex_1 • UHC_ER Hospital Claim_Ex_2 • UHC_ER OON Medical Claim_Ex_3 • UHC_ ER_Claim_Configuration_Narrative **Additional Documentation:** • Std_IV_Item_4_5_6_7_Follow_Up_Service_Definition_User_Guide • Std_IV_Item_4_5_6_7_Follow_Up_Service_Payment_(SEPY)_Standard	
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system, CSP Facets, is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
CSP Facets configuration exists to ensure appropriate handling of claims billing emergency services as evidenced in the UHC_ER_Claim_Configuration_Narrative. The UHC_LA H Inpatient Authorization SOP provides guidance to claim processors when handling inpatient claims billed with emergency services and the inpatient stay is denied.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE does not deny payment for treatment obtained under either of the following circumstances: a. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes as specified in the definition of "emergency medical condition." b. A representative of the MCE instructs the member to seek emergency services. 42 CFR §438.114(c)(1)(ii) 42 CFR §457.1228 MCO Contract: 2.11.8.4 PAHP Contract: 2.4.2.3.3; 2.4.2.3.4 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • Process to track when an MCE representative instructs a member to seek emergency services (e.g., member services, care management) • 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) **Evidence as Submitted by the MCE:** • LA New Member Insert, Page 3, Emergency Care, instructions for new members. Page 6, Emergency Care, instructions for new members. • UHC Provider Manual, page 45, right column under Emergent/Urgent Care Services – defines covered emergent/urgent services • UHC_ Med_Emergency_Mbr_Serv_SOP; All pages	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• UHC_LA H Inpatient Authorization SOP Page 11-18 • UHC_ER Hospital Claim_ Ex_1 • UHC_ER Hospital Claim_Ex_2 • UHC_ER OON Medical Claim_Ex_3 • UHC_ER_Claim_Configuration_Narrative **Additional Documentation:** • Std_IV_Item_4_5_6_7_Follow_Up_Service_Definition_User_Guide • Std_IV_Item_4_5_6_7_Follow_Up_Service_Payment_(SEPY)_Standard	
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system, CSP Facets, is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service. CSP Facets configuration exists to ensure appropriate handling of claims billing emergency services as evidenced in the UHC_ER_Claim_Configuration_Narrative. The UHC_LA H Inpatient Authorization SOP provides guidance to claim processors when handling inpatient claims billed with emergency services and the inpatient stay is denied. In the event of an emergency medical situation, Member Service Advocates (MSAs) utilize UHC_Standard_IV_5_Med_Emergency_Mbr_Serv_SOP to assist the caller with obtaining immediate help.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Additional Rules for Emergency Services		
6. The MCE does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms. 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. 42 CFR §438.114(d)(1) 42 CFR §457.1228 MCO Contract: 2.11.8.3; 2.11.8.5 PAHP Contract: 2.8.3.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency services • 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) **Evidence as Submitted by the MCE:** • LA New Member Insert, Page 3, Emergency Care, instructions for new members. Page 6, Emergency Care, instructions for new members. • UHC Provider Manual, page 45, right column under "Emergent/Urgent Care Services", scroll down to "Covered services include" – lists covered emergent & post stabilization services with no reference t specific diagnoses or other requirements. • UHC_LA H Inpatient Authorization SOP Page 11-18 • UHC_ER Hospital Claim_ Ex_1 • UHC_ER Hospital Claim_Ex_2 • UHC_ER OON Medical Claim_Ex_3 • UHC_ER_Claim_Configuration_Narrative	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Std_IV_Item_4_5_6_7_Follow_Up_Service_Definition_User_Guide • Std_IV_Item_4_5_6_7_Follow_Up_Service_Payment_(SEPY)_Standard	
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system, CSP Facets, is configured to allow emergency services by any provider in the US or its territories, and SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service. CSP Facets configuration exists to ensure appropriate handling of claims billing emergency services as evidenced in the UHC_ER_Claim_Configuration_Narrative. The UHC_LA H Inpatient Authorization SOP provides guidance to claim processors when handling inpatient claims billed with emergency services and the inpatient stay is denied.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.114(d)(2) 42 CFR §457.1228 MCO Contract: 6.36.2 PAHP Contract: 2.8.3 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual • Claim payment algorithm for emergency and poststabilization services • 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)	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • Member Handbook, top of page 26 under Post-stabilization services • UHC Provider Manual 2024, page 48, last paragraph – confirmation of post-stabilization services coverage and liability. • UHC_ LA H Inpatient Authorization SOP Page 11-18 • UHC_ER Hospital Claim_ Ex_1 • UHC_ER Hospital Claim_Ex_2 • UHC_ER OON Medical Claim_Ex_3 • UHC_ER_Claim_Configuration_Narrative • UHC_Standard_IV_7_Post_Stabilization_Narrative **Additional Documentation:** • Std_IV_Item_4_5_6_7_Follow_Up_Service_Definition_User_Guide • Std_IV_Item_4_5_6_7_Follow_Up_Service_Payment_(SEPY)_Standard • Std_IV_Item_7_Documentation_to_Support_the_Post_Stabilization_Narrative • IV. 7,9,10,11,12 Post_Stabilization_Intent_Narrative	
MCE Description of Process: UHC Customer Service & Clinical teams both encourage immediate attention for emergency situations, erroring on the side of caution. Our claim system, CSP Facets, is configured to allow emergency services by any provider in the US or its territories, and		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
SOPs remind processors to allow out-of-area and out-of-network emergency claims to bypass any edits imposed on most other non-PAR claims. No edits are in place that would require specific diagnoses to justify an emergency service. Louisiana Medicaid has no member cost-sharing for medical or behavioral health services. As a result, there are no charges to members for post-stabilization services in or out of network. CSP Facets configuration exists to ensure appropriate handling of claims billing emergency services as evidenced in the UHC_ ER_Claim_Configuration_Narrative. The UHC_4_LA H Inpatient Authorization SOP provides guidance to claim processors when handling inpatient claims billed with emergency services and the inpatient stay is denied.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.114(d)(3) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: 2.4.2.3.5 PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Three case examples of a peer-to-peer discussion between the MCE and emergency provider pertaining to emergency services **Evidence as Submitted by the MCE:** • Consumer Safety Policy, page 5, lower left quadrant, Sections 2.11.8.8 through 2.11.8.8.4 • UHC Provider Manual 2024, page 64, right-hand column under Discharge Coordination • Narrative_Emergency & Post-stabilization Peer-to-Peer Requests	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Emergent and urgent services are covered with no auth required. Our attached Narrative, compiled by Medical Director ……, explains why we would never need Peer-to-Peer discussions for Emergency & Post-Stabilization Services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
Coverage and Payment of Poststabilization Care Services		
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. 42 CFR §422.113(c)(2)(i) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7 PAHP Contract: 2.4.2.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for post stabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • UHC Provider Manual 2024, page 48, last paragraph – confirmation of post-stabilization services coverage and liability, both in and out-of-network • Consumer Safety Policy, page 5, upper left quadrant, Sections 2.11.8.7 through 2.11.8.7.1 • UHC_ Post Stabilization Claim_Ex_1 • UHC_ Post Stabilization Claim_Ex_2 • UHC_ Post Stabilization_OON Claim_Ex_3 • UHC__Post_Stabilization_Narrative **Additional Documentation:** • IV. 7,9,10,11,12 Post_Stabilization_Intent_Narrative	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
10. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or other MCE representative, but administered to maintain the member's stabilized condition within one hour of a request to the MCE for pre-approval of further poststabilization care services. 42 CFR §422.113(c)(2)(ii) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.7.2.1 PAHP Contract: 2.4.2.2.1.2 PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services **Evidence as Submitted by the MCE:** • UHC Provider Manual 2024, page 48, last paragraph – confirmation of post-stabilization services coverage and liability, both in and out-of-network • Consumer Safety Policy, page 5, upper left quadrant, Sections 2.11.8.7 through 2.11.8.7.2.3 • UHC_Post_Stabilization_Narrative **Additional Documentation:** • IV. 7,9,10,11,12 Post_Stabilization_Intent_Narrative	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
11. The MCE is financially responsible for poststabilization care services obtained within or outside the MCE that are not pre-approved by a plan provider or MCE representative, but administered to maintain, improve, or resolve the member's stabilized condition if: a. The MCE does not respond to a request for pre-approval within one hour. b. The MCE cannot be contacted. 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. 42 CFR §422.113(c)(2)(iii) 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 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	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual • Workflow for claims review process for poststabilization services • Process to track requests for pre-approval of poststabilization care services and timeliness of the MCE's response • One case example of a peer-to-peer discussion between the MCE and the treating provider pertaining to poststabilization care services **Evidence as Submitted by the MCE:** • Consumer Safety Policy, page 5, upper left quadrant, Sections 2.11.8.7 through 2.11.8.7.2.3 • UHC Provider Manual 2024, page 48, last paragraph – confirmation of post-stabilization services coverage and liability, both in and out-of-network • UHC_Post_Stabilization_Narrative • Narrative_ Emergency & Post Stabilization Peer to Peer Requests **Additional Documentation:** • IV. 7,9,10,11,12 Post_Stabilization_Intent_Narrative	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Louisiana Medicaid has no member cost-sharing for medical or behavioral health services. As a result, there are no charges to members for post-stabilization services in or out of network. We have no peer-to-peer discussion requests for these services. Our corresponding Narrative includes commentary from one of our Medical Directors.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. The MCE limits charges to members for poststabilization care services to an amount no greater than what the MCE would charge the member if he or she had obtained the services through the MCE. For purposes of cost-sharing, poststabilization care services begin upon inpatient admission. 42 CFR §422.113(c)(2)(iv) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: None PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Workflow for claims review process for poststabilization services • Three case examples of a provider submitted claim for poststabilization care services with screenshots of the adjudicated claim (one example must be from an out-of-network provider) **Evidence as Submitted by the MCE:** • UHC Provider Manual 2024, page 48, last paragraph – confirmation of post-stabilization services coverage and liability, both in and out-of-network • Consumer Safety Policy, page 5, upper left quadrant, "Sections 2.11.8.7 through 2.11.7.7.2.3 • UHC_Post Stabilization Claim_Ex_1 • UHC_ Post Stabilization Claim_Ex_2 • UHC_ Post Stabilization_OON Claim_Ex_3	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
	• UHC_ Post_Stabilization_Narrative **Additional Documentation:** • IV. 7,9,10,11,12 Post_Stabilization_Intent_Narrative	
MCE Description of Process: Louisiana Medicaid has no member cost-sharing for medical or behavioral health services. As a result, there are no charges to members for post-stabilization services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
End of the MCE's Financial Responsibility		
13. The MCE's financial responsibility for poststabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care. b. A plan physician assumes responsibility for the member's care through transfer. c. An MCE representative and the treating physician reach an agreement concerning the member's care. d. The member is discharged. 42 CFR §422.113(c)(3) 42 CFR §438.114(e) 42 CFR §457.1228 MCO Contract: 2.11.8.8 PAHP Contract: None PIHP Contract: 8.8.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • Consumer Safety Policy, page 5, bottom left, Sections 2.11.8.8 through 2.11.8.8.4 • UHC Provider Manual, page 30, 4th item in "Services Included" column. Defines MCE liability up to the point of medical stabilization • UHC Provider Manual, page 31, 7th paragraph in "Services Included" column. Defines MCE liability for Emergency & Post Stabilization • UHC Provider Manual, page 45, last paragraph defines MCE liability for Emergency & Post Stabilization Services	☒ Met ☐ Not Met ☐ NA

Standard IV—Emergency and Poststabilization Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IV—Emergency and Poststabilization Services							
Total	Met	=	13	X	1	=	13
	Not Met	=	0	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	13	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**100%**

Standard V—Adequate Capacity and Availability of Services

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Delivery Network		
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. 42 CFR §438.206(b)(1) 42 CFR §457.1230(a) 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	**HSAG Required Evidence:** • Policies and procedures • Analysis of provider network linguistic capabilities • Analysis of provider network capabilities to serve members with special health care needs • Provider materials, such as the provider manual • One example of each type of provider contract (ancillary, hospital, and individual/group) **Evidence as Submitted by the MCE:** • 2024 Net 1-3 Report Final NQOC approved-Assessment of Cultural & Linguistic NW Responsiveness – pages 20-27 of document • LA IntegratedHealth Handbook, page 60, last 3 paragraphs - defines benefit and process for accessing Interpreter Services. • Provider Manual, top of page 4, under Materials for limited English-speaking enrollees. • Narrative_Online Directory with Language Filter • Narrative_Cult Comp with screenshot • Provider Manual • Examples of provider contracts:	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	– Sample Ancillary Agreement – Sample Individual Provider Agreement – Sample Provider Group Agreement – UHC Sample Facility Agreement **Additional Documentation:** • V.1,9_UHC Network Accessibility and Availability Adequacy Rpt 220_Submitted to LDH June 2025	
MCE Description of Process: Our Provider Manual, listed above as a resource, provides everything from basic instructions to join our Network (p. 67), to After Hours services (p. 67) and other requirements, to reminding providers that Administrative Terminations may occur due to inactivity (p. 14)		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence from the audit time frame that the MCE monitored its provider network's capabilities to ensure that its provider network 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. UHC also did not submit a policy or procedure related to maintaining and monitoring its provider network ensuring adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities. **Recommendations:** HSAG recommends that UHC develop a policy that ensures how UHC maintains and monitors a network of appropriate providers 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.		
Required Actions: 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 or mental disabilities.		
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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Coverage/authorization guidelines	☒ Met ☐ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
member's designated source of primary care if that source is not a women's health specialist. 42 CFR §438.206(b)(2) 42 CFR §457.1230(a) MCO Contract: 2.9.17 PAHP Contract: NA PIHP Contract: NA	**Evidence as Submitted by the MCE:** • LA IntegratedHealth Handbook, page 14, "Your Primary Care Provider (PCP)" – emphasizes that women can select some OBs and GYNs as their PCP • LA IntegratedHealth Handbook, page 23. 2nd paragraph under Prior Authorizations – Women's Health Services available with no prior auth. • LA IntegratedHealth Handbook, page 39. 3rd item in chart – Women's Health Services • Narrative – Specialist as PCP – documents how our member call team can link a member to an OB/GYN or other specialist when both parties agree to a PCP/member relationship	
MCE Description of Process: Female members of child-bearing age can elect to choose an OB or GYN provider as their PCP, or they can chose a traditional PCP, and self-refer as needed to the In Network OB or GYN of their choice.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. UHC did not provide a policy or procedure regarding female members' 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. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines female members' 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.		
Required Actions: No action required.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
3. The MCE demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. 42 CFR §438.206(b)(7) 42 CFR §457.1230(a) MCO Contract: 2.9.17.1 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • List of provider types designated as family planning providers • Network adequacy analysis of family planning providers **Evidence as Submitted by the MCE:** • LA IntegratedHealth Handbook, page 32, bottom of chart. Documentation shows no Prior Auth requirements for Family Planning services. • LA IntegratedHealth Handbook, page 90, center of page, "Copays are not Required for:" – documents there are no pharmacy copays for Family Planning items received from a POS pharmacy. • Narrative – Family Planning Contract Langauge	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Per our contract with LDH, our Medicaid members have no restrictions around Family Planning providers. They can utilize their PCP, OB or GYN, or they can receive services from any Family Planning provider – PAR or non-PAR. Our claims system is configured to pay Family Planning claims from any valid provider. No authorization required, no contract required. We do not have a defined list of provider types designated as family planning providers since so many specialties can accommodate. We also have not, historically, completed an analysis of family planning providers.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not demonstrate that its network included sufficient family planning providers to ensure timely access to covered services. UHC also did not provide a policy or procedure that demonstrated how UHC ensured its network had sufficient family planning providers to ensure timely access to covered services. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how it will demonstrate that its network has sufficient family planning providers to ensure timely access to covered services.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Required Actions: The MCE must ensure, through monitoring and data analysis, that its network includes sufficient family planning providers to ensure timely access to covered services.		
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. 42 CFR §438.206(b)(3) 42 CFR §457.1230(a) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Second opinion tracking/analysis • Coverage/authorization guidelines **Evidence as Submitted by the MCE:** • LA IntegratedHealth Handbook, page 22, last paragraph. Documentation shows availability of 2nd opinions **Additional Documentation:** • V.4 Narrative for Second Opinion • UHC Member Handbook 2024 AB.pdf Pg 22	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: There is no specific CPT or HCPCS for a Second Opinion, and we do not require prior authorization. If a member is engaged in Case Management the case manager may assist the member in locating a provider for a second opinion, but we will not always be aware that a member sought a second opinion on their own, so general tracking of second opinions has not proved worthwhile. If abuse of the process was identified, or if members often sought second opinions after seeing a specific provider, this could trigger further investigation by our SIU or FW&A teams.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide policies regarding second opinions or coverage and authorization guidelines for a second opinion from a network provider, or arranging for the member to obtain one outside the network, at no cost to the member.		
Required Actions: The MCE must develop a policy or written process document for providing a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.206(b)(4) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Network adequacy monitoring mechanisms • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • Single Case Agreements (SCAs) – Internal Process: UHC's internal document supporting the creation and execution of SCAs • LA IntegratedHealth Handbook, page 14, last paragraph, describes situations where members may need to see an OON provider, with instructions for members to prevent financial liability. • LA IntegratedHealth Handbook, page 22, 2nd paragraph, describes situations where members may need to see an OON provider, and how authorization will likely be required (initiated by their INN referring provider if possible • LA IntegratedHealth Handbook, page 23, 4th paragraph, confirms prior auth is required to see most OON providers. • Narrative – SCAs not due to Adequacy Issues • Network Adequacy Reporting – shows 0 or minimal gaps in coverage. SCAs aren't filling	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	adequacy gaps, they are allowing members to receive services not available in Louisiana – Q1 & Q2 220 Network Adequacy report – Q3 & Q4 220 Network Adequacy report • 3 examples-Single Case Agreements (SCAs) – SCA Sample 1_..... – SCA Sample 2_..... – SCA Sample 3_.....	
MCE Description of Process: Our SCAs are rarely, if ever, executed to fill adequacy gaps. The majority are for health care entities & individuals outside the state of Louisiana who provider specific services not available from any provider in the state.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence of a monitoring mechanism ensuring that UHC adequately and timely covered necessary services utilizing out of network providers, for as long as the MCE provider network was unable to provide them. UHC also did not provide policies regarding second opinions, coverage and authorization guidelines for a second opinion from a network provider or arranging for the member to obtain one outside the network, at no cost to the member. **Recommendations:** HSAG recommends that the MCE develop a policy that ensures that UHC adequately and timely covers necessary services utilizing out of network providers, for as long as the MCE provider network is unable to provide them, including claims processing guidelines. Additionally, UHC stated in narrative form that "[f]or non-emergent services, we do not execute an SCA if the OON provider agrees to be reimbursed at the standard LA Medicaid Fee Schedule. SCAs are executed only when we must reimburse a provider at a rate other than the LA Medicaid Fee Schedule." HSAG recommends that UHC execute SCAs for all services rendered by out-of-network providers.		
Required Actions: The MCE must develop a monitoring mechanism to ensure that the MCE adequately and timely covers necessary services utilizing out-of-network providers, for as long as the MCE provider network is unable to provide them.		
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.	**HSAG Required Evidence:** • Policies and procedures • Claims processing guidelines • Member materials, such as the member handbook	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.206(b)(5) 42 CFR §457.1230(a) MCO Contract: 2.9.2.3 PAHP Contract: 2.6.1.8 PIHP Contract: 6.2.3.1.7	• Provider materials, such as materials on the MCE's website • Three examples of executed single case agreements **Evidence as Submitted by the MCE:** • LA IntegratedHealth Handbook, page 14, last paragraph, describes situations where members may need to see an OON provider, with instructions for members to prevent financial liability. • LA IntegratedHealth Handbook, page 22, 2nd paragraph, describes situations where members may need to see an OON provider, and how authorization will likely be required (initiated by their INN referring provider if possible • LA IntegratedHealth Handbook, page 23, 4th paragraph, confirms prior auth is required to see most OON providers. • Single Case Agreements (SCAs)_3 examples – SCA Sample 1_..... – SCA Sample 2_..... – SCA Sample 3_.....	
MCE Description of Process: OON providers who provider emergency services to our members are systematically reimbursed at the Louisiana Medicaid rates, no human intervention involved. For non-emergent services, we do not execute an SCA if the OON provider agrees to be reimbursed at the standard LA Medicaid Fee Schedule. SCAs are executed only when we must reimburse a provider at a rate other than the LA Medicaid Fee Schedule.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Since LA Medicaid has no cost sharing with members for medical or behavioral health services, there is no differential when services are reimbursed via an SCA.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence, such as a policy, claims processing guidelines, or provider materials, that required out-of-network providers to coordinate with UHC for payment and ensured the cost to the member is no greater than it would be if the services were furnished within the network. **Recommendations:** HSAG recommends that the MCE develop a policy and provider materials, inclusive of claims processing guidelines, that 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. Additionally, UHC stated in narrative form that "[f]or non-emergent services, we do not execute an SCA if the OON provider agrees to be reimbursed at the standard LA Medicaid Fee Schedule. SCAs are executed only when we must reimburse a provider at a rate other than the LA Medicaid Fee Schedule." Additionally, HSAG recommends that UHC execute SCAs for all services rendered by out-of-network providers.		
Required Actions: The MCE must require 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.		
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]		
Timely Access		
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. 42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: 2.9.3.1 PAHP Contract: 2.6.5.1; 2.6.5.3 PIHP Contract: 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Network analysis (e.g., appointment standards) • HSAG will also use the results of the Access Standards: Appointment Times Checklist **Evidence as Submitted by the MCE:** • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• UHC Provider Manual, page 21, last paragraph under Ancillary Care Provider Responsibilities – timely access to care • Sample Individual Provider Agreement, bottom of page 21, item c Availability of Services	
MCE Description of Process: Our provider contracts support the same requirement pushed to the MCOs via LDH. The 1st attachment referenced is a detailed report/survey of appointment availability based on member wait times.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's Appointment Times Checklist was also used by the HSAG reviewer to evaluate this requirement, and areas of noncompliance were identified. UHC did not provide a policy requiring its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. **Recommendations:** HSAG recommends that the MCE develop a policy requiring its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.		
Required Actions: 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.		
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) MCO Contract: 2.9.3.2	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • Provider Manual, page 15, left column under Office Hours – Providers must have same office hours for Medicaid as they have for Commercial members.	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.6.2.4 PIHP Contract: NA	• Sample Individual Provider Agreement, page 21, section c – Provider shall offer hours of operation that are no less than those offered to commercial beneficiaries. • 2024 UnitedHealthcare Report – Appointment Availability – this survey/audit measures office wait times to determine true availability. – Provided as a whole document – no specific call outs **Additional Documentation:** • V 8,9 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	
MCE Description of Process: Secret Shopper – there were no LDH-initiated Secret Shopper audits in 2024, as the state focused closely on a provider adequacy cleanup/remediation project during this time.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence that it monitored its network providers to ensure providers offered hours of operation that were no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for service (FFS) if the provider served only Medicaid members. UHC also did not submit a policy or procedure concerning the requirements of this element. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how 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 FFS if the provider serves only Medicaid members.		
Required Actions: The MCE must ensure, through monitoring and data analysis, 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 FFS if the provider serves only Medicaid members.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
9. The MCE makes services included in the contract available 24 hours a day, seven days a week, when medically necessary. 42 CFR §438.206(c)(1)(iii) 42 CFR §457.1230(a) MCO Contract: 2.9.3.3 PAHP Contract: 2.9.10.2 PIHP Contract: 5.11.6	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Results of provider monitoring mechanisms • Audit or secret shopper results/reports **Evidence as Submitted by the MCE:** • Sample Individual Provider Agreement, Section C, top of page 21 • 2024 NET 1-3 Report Final NQOC approved Section 2 Accessibility of Practitioners – pages 12 – 19 **Additional Documentation:** • V 8,9 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY • V.1,9_UHC Network Accessibility and Availability Adequacy Rpt 220_Submitted to LDH June 2025 • Std_V_Item_9_Narrative_No LDH Secret Shopper Audits in 2024	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Note that there were no LDH-initiated Secret Shopper initiatives in 2024, as the concentration was on clean up and remediation of provider adequacy data – old addresses, etc.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence that it ensures its network providers make services included in the contract available 24 hours a day, seven days a week, when medically necessary. UHC also did not submit a policy or procedure concerning the requirements of this element.		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that the MCE develop a policy that outlines how it ensures that its network providers make services included in the contract available 24 hours a day, seven days a week, when medically necessary.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that its network providers make services included in the contract available 24 hours a day, seven days a week, when medically necessary.		
10. The MCE establishes mechanisms to ensure compliance with timely access to care and services standards by network providers. a. The MCE monitors network providers regularly to determine compliance. b. The MCE takes corrective action if there is a failure to comply by a network provider. 42 CFR §438.206(c)(1)(iv-vi) 42 CFR §457.1230(a) MCO Contract: 2.9.3.5 PAHP Contract: 2.6.5.2 PIHP Contract: 6.8.6; 7.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Results of provider monitoring mechanisms • Audit or secret shopper results/reports • Three examples of corrective action taken when a provider fails to meet timely access standards **Evidence as Submitted by the MCE:** • Results & Audit - 2024 NET 1-3 Report Final NQOC approved Section 2 Accessibility of Practitioners – pages 12 – 19. Cultural & Linguistic – pages 20-27. • 2024 UnitedHealthcare Report_APPOINTMENT AVAILABILITY • Corrective Action Template Letters: – 2024 Appointment Availability Letter Template – 2024 After Hours Letter Template	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Corrective Action – Providers are sent one or both of the above letters when they are non-compliant. Those same providers are automatically re-surveyed the following year to ensure compliance.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. In its appointment availability monitoring report, UHC stated that it surveyed "non-compliant providers from the prior year" and found that "less than half (41%) of all re-surveyed providers are now compliant (48 of 117 re-surveyed providers)." UHC did not provide evidence of corrective action plans for those providers		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
who were surveyed and remained noncompliant two years in a row. UHC also did not provide a policy concerning the requirements of this element. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how it ensures compliance with timely access to care and services standards by network providers, including monitoring its network providers regularly to determine compliance and taking corrective action if there is a failure to comply by a network provider.		
Required Actions: The MCE must establish mechanisms to ensure compliance with timely access to care and services standards by network providers, including monitoring its network providers regularly to determine compliance and taking corrective action if there is a failure to comply by a network provider.		
Access and Cultural Considerations		
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. 42 CFR §438.206(c)(2) 42 CFR §457.1230(a) MCO Contract: 2.4.1.11 PAHP Contract: 2.1.2 PIHP Contract: 5.1.8	**HSAG Required Evidence:** • Policies and procedures • Provider materials, such as the provider manual and provider contract • Cultural competency plan • Example(s) of provider profiles (e.g., cultural and linguistic capabilities) on provider directory • Analysis of provider network linguistic capabilities • Analysis of provider network cultural competence **Evidence as Submitted by the MCE:** • Narrative_ Cult Comp with Screenshot.docx • Narrative_Online Directory with Language Filter • 2024 NET 1-3 Report Final NQOC approved_Assessment of Cultural & Linguistic Network Competence, pages 20-27.	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
	• Provider Profiles on directory: – Narrative_Online Directory_Sample provider – Narrative_Paper Directory_Sample providers **Additional Documentation:** • V 11 LA Medicaid and CHIP Regulatory Requirements Appendix, page 29 Section F	
MCE Description of Process: UHC's online provider Directories are searchable by Language, services provided such as MAT or Aids treatment, Telehealth, Patient Reviews, LGBTQ+ Supportive, Age Expertise, Evening/Weekend Availability, Gender, Accepting New Patients, and/or Hospital Affiliations.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence of an analysis of its provider network's linguistic capabilities and cultural competence within the audit time frame. UHC also did not submit a policy concerning the requirements of this element. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how it promotes and monitors 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.		
Required Actions: The MCE must ensure, through monitoring and data analysis, that network providers deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.		
Accessibility Considerations		
12. The MCE ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. 42 CFR §438.206(c)(3) 42 CFR §457.1230(a)	**HSAG Required Evidence:** • Policies and procedures • Provider materials such as the provider manual and provider contract • Mechanism to assess network providers' accessibility	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.9.2.2 PAHP Contract: 2.6.9.5.4 PIHP Contract: 5.13.1.1.21; 6.1.14	• 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 • Analysis of provider network capability to provide services to members with physical or mental disabilities • Surveys or site review results	
	Evidence as Submitted by the MCE: • Sample Individual Provider Agreement, page 22, Section f. • Provider Manual, page 91- QOC complaints result in site visits. • Provider Profiles – samples from Directory – Narrative_Online Directory_Sample Provider – Narrative_Paper Directory_Sample Provider • Medical Providers – Q1 & Q2 220 Network Adequacy – Q3 & Q4 220 Network Adequacy • Behavioral Health Providers – 328 Q1 2024 – 328 Q2 2024 – 328 Q3 2024 – 328 Q4 2024 • 2024 UnitedHealthcare Report Appointment Availability	

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UHC's online provider Directories are searchable by Language, services provided such as MAT or Aids treatment, Telehealth, Patient Reviews, LGBTQ+ Supportive, Age Expertise, Evening/Weekend Availability, Gender, Accepting New Patients, and/or Hospital Affiliations. Established flags call out accessibility – public transportation, accessible restrooms, exam room accommodations, accessible interior, and accessible exterior building analysis.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide evidence that it ensured, through monitoring and data analysis, that network providers provided physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities. UHC also did not submit a policy concerning the requirements of this element. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how it ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid members with physical or mental disabilities.		
Required Actions: 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		
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). a. The MCE submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: 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. ii. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet	**HSAG Required Evidence:** • Policies and procedures • Network adequacy reports/analyses • Exceptions approved by the State • HSAG will also use the results of the Access Standards: Time/Distance Checklist • HSAG will also use the results of the Access Standards: Member-to-Provider Ratio Checklist **Evidence as Submitted by the MCE:** • Network Adequacy Reports – medical – Q1 & Q2 220 Network Adequacy Geo Access – Q3 & Q4 220 Network Adequacy Geo Access	☐ Met ☒ Not Met ☐ NA

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
the needs of the anticipated number of members in the service area. PIHP a. The PIHP shall submit an attestation ensuring adequate capacity as defined by the contractual GEO Access Standards and services upon execution of the Contract and at any time there has been a change in the PIHP's operations that would potentially impact adequate capacity and services (e.g., changes in services, benefits, payments, or enrollment of a new population). 42 CFR §438.207(a) 42 CFR §438.207(b)(1-2) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.6.4; 2.6.5 PIHP Contract: 6.2.3.1; 6.3.2	• Network Adequacy reports – behavioral – 328 Q1 2024 – 328 Q2 2024 – 328 Q3 2024 – 328 Q4 2024 **Additional Documentation:** • V.13 Vc Checklist 348 GeoAccess Reports.zip • V.13, 14 Network Adequacy Submission to LDH Verification	
MCE Description of Process: Tab 5 of the above referenced semi-annual Network Adequacy Reports list and analyse all practitioners subject to adequacy reporting. While these complete reports are submitted semi-annually, Tab 5 of the same report is submitted every month, so there is a constant monitoring and analysis of any potential network gaps. UHC did not request any exceptions in 2024, so we have no approved exceptions.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC'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. UHC did not provide a policy concerning the requirements of this element. Of note, UHC staff members stated that UHC did not request any exceptions from the State. **Recommendations:** HSAG recommends that the MCE develop a policy that outlines how it 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).		
Required Actions: The MCE must offer 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 and maintain a network of providers that is		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. Refer to the Access Standards: Time/Distance Checklist and Member-to-Provider Ratio Checklist for specific areas of noncompliance.		
Timing		
14. The MCE submits the documentation in 42 CFR §438.207(b) as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. 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: i. Changes in MCE services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population in the MCE. 42 CFR §438.207(c) 42 CFR §457.1230(b) MCO Contract: 2.9.1.2 PAHP Contract: 2.1.5.2 PIHP Contract: 6.3.2; 6.2.1; 6.2.2	**HSAG Required Evidence:** • Policies and procedures • Assurances of adequate capacity and services submissions to the State (annual and/or as required by the State) • Assurances of adequate capacity and services submission to the State due to a significant change **Evidence as Submitted by the MCE:** • Q1 & Q2 220 Network Adequacy Geo Access • Q3 & Q4 220 Network Adequacy Geo Access **Additional Documentation:** • V.13, 14 Network Adequacy Submission to LDH Verification	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Louisiana MCEs submit a thorough network analysis via our semi-annual and monthly 220 Network Adequacy Geo Access reports. Tab 5 of the above referenced semi-annual Network Adequacy Reports list and analyze all practitioners subject to adequacy reporting. While these complete reports are submitted semi-annually, Tab 5 of the same report is submitted every month, so there is a constant monitoring and analysis of any potential network gaps. We had no significant changes in 2024 that would have justified an additional, separate analysis (item c.) We had no significant changes in services, benefits, geographic service area (we've covered the entire state since 2012), or composition of payments to our providers (item d.) There were no new enrollee populations in 2024 (item e.)		

Standard V—Adequate Capacity and Availability of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. UHC did not submit a policy concerning the requirements of this element. HSAG recommends that the MCE develop a policy that specifies the timing of network adequacy reporting submissions. Of note, UHC staff members stated that in 2024, the MCE did not experience any significant changes (as defined by the State) in its operations that would affect the adequacy of capacity in services.		
Required Actions: No action required.		
Exceptions Process		
15. To the extent the State permits an exception to any of the provider-specific network standards, MCO: a. *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.* PAHP: a. *Requests for exceptions as a result of prevailing community standards must be submitted in writing to LDH for approval.* PIHP: a. *Requests for exceptions as a result of prevailing community standards for geographic accessibility standards must be submitted in writing to LDH for approval.* 42 CFR §438.68(d) 42 CFR §438.207 42 CFR §457.1230(b)	**HSAG Required Evidence:** • Policies and procedures • Network monitoring report(s) • Exceptions requested by the MCE, if applicable • Exceptions approved by the State, if applicable **Evidence as Submitted by the MCE:** • Network Monitoring Reports – Q1 & Q2 220 Network Adequacy Geo Access – Q3 & Q4 220 Network Adequacy Geo Access	☐ Met ☐ Not Met ☒ NA

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		
MCE Description of Process: Tab 5 of the above referenced semi-annual Network Adequacy Reports list and analyze all practitioners subject to adequacy reporting. While these complete reports are submitted semi-annually, Tab 5 of the same report is submitted every month, so there is a constant monitoring and analysis of any potential network gaps. *Exception Requests – UHC had none in 2024, so therefore there were also no Exception Approvals*		
HSAG Findings: UHC staff members stated during the interview session that the MCE had no exceptions to any of the provider-specific network standards in 2024; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		

Results for Standard V—Adequate Capacity and Availability of Services							
Total	Met	=	2	X	1	=	2
	Not Met	=	12	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	14	**Total Score**		=	2

Total Score ÷ Total Applicable	=	**14%**

Access Standards: Appointment Times Checklist

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
Primary Care Physician Access Standards		
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. *MCO:* a. *PCP appointments are available as follows:* i. *Non-urgent sick primary care: 72 hours* ii. *Non-urgent routine primary care: 6 weeks* *PAHP:* a. *Primary dental care: within 30 days* b. *Follow-up dental services: within 30 days after assessment* **Evidence as submitted by the MCE:** • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	Y ☐ N ☒ NA ☐
Specialty Care Physician Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Amendment 2, Attachment F PAHP Contract: 2.6.5.3; 2.6.2.7 PIHP Contract: None	2. *MCO:* a. *For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers, the MCO shall provide*: b. *Specialist appointments: one month* c. *Non-urgent routine behavioral health care: 14 days* d. *Urgent non-emergency behavioral health care: 48 hours* e. *ASAM Level 3.3, 3.5, and 3.7: 10 business days* f. *Residential withdrawal management: 24 hours when medically necessary* g. *Psychiatric Residential Treatment Facility (PRTF): 20 calendar days*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	PAHP: a. *Referrals to participating specialists (endodontists, maxillofacial surgeons, oral surgeons, orthodontists, pedodontists, periodontists, prosthodontists, and special needs pedodontists) are available as follows:* 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;* ii. *Primary dental care: within 30 days* iii. *Follow-up dental services: within 30 days after assessment* *PIHP:* a. *Urgent non-emergency behavioral health care: 48 hours*	
	Evidence as submitted by the MCE: • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	
Hospital and Emergency Services Access Standards		
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. *MCO:* a. *Emergency care: 24 hours, 7 days/week within one hour of request* b. *Urgent non-emergency care: 24 hours, 7 days/week within 24 hours of request* c. *After hours, by phone: answer by live person or call back from a designated medical practitioner within 30 minutes* *PAHP:* a. *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;* *PIHP:* a. *Emergent care: 24 hours, 7 days/week within one hour of request* b. *Emergent, crisis or emergency services must be available at all times.* c. *Urgent care: 24 hours, 7 days/week within 48 hours of request*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Appointment Times Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	
Prenatal Care and Family Planning Access Standards		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: Attachment F PAHP Contract: NA PIHP Contract: NA	4. *MCO:* a. *OB/GYN care for pregnant women:* i. *1st trimester: 14 days* ii. *2nd trimester: 7 days* iii. *3rd trimester: 3 days* iv. *High risk pregnancy, any trimester: 3 days* b. *Family planning appointments: 1 week*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILITY	
Office Waiting Times		
42 CFR §438.206(c)(1)(i) 42 CFR §457.1230(a) MCO Contract: None PAHP Contract: None PIHP Contract: None	5. *MCO:* *PAHP:* *PIHP:*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • 2024 UnitedHealthcare Report APPOINTMENT AVAILABILIT	

Access Standards: Member-to-Provider Ratio Checklist

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
Primary 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	1. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1:1,000* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☒ N ☐ NA ☐
Hospitals		
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. *Acute Inpatient Hospitals* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☐ N ☐ NA ☒
Ancillary		
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. *Laboratory* 5. *Radiology* 6. *Pharmacy* 7. *Hemodialysis Centers* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Member-to-Provider Ratio Checklist		
Reference	**Required Components**	
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. *OB/GYN: 1:10,000* 9. *Allergy/Immunology: 1:100,000* 10. *Cardiology: 1:20,000* 11. *Dermatology: 1:40,000* 12. *Endocrinology and Metabolism: 1:25,000* 13. *Gastroenterology: 1:30,000* 14. *Hematology/Oncology: 1:80,000* 15. *Nephrology: 1:50,000* 16. *Neurology: 1:35,000* 17. *Ophthalmology: 1:20,000* 18. *Orthopedics: 1:15,000* 19. *Otorhinolaryngology/Otolaryngology: 1:30,000* 20. *Urology: 1:30,000* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☐ N ☒ NA ☐
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. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC): 1:2,500* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☒ N ☐ NA ☐

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. *Adult Physician Extenders: 1:1,000* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☒ N ☐ NA ☐
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. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC): 1: 2,500* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☒ N ☐ NA ☐
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. *Pediatric Physician Extenders: 1: 1,000* **Evidence as submitted by the MCE:** • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	Y ☒ N ☐ NA ☐

Access Standards: Time/Distance Checklist

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Primary Care		
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. *Adult PCP (Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 2. *Pediatric PCP (Pediatrics; Family/General Practice; Internal Medicine; FQHC; RHC):* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 3. *Primary Dental Services:* *a. Rural Parishes: 30 miles one-way* *b. Urban Parishes: 10 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	
Hospitals		
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. *Acute Inpatient Hospitals* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Ancillary		
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. *Laboratory:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 6. *Radiology:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 20 miles* 7. *Pharmacy:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles* 8. *Hemodialysis Centers:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 10 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	
Specialty Care		
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. *OB/GYN:* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* 10. *Allergy/Immunology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 11. *Cardiology:* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	12. *Dermatology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 13. *Endocrinology and Metabolism:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 14. *Gastroenterology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 15. *Hematology/Oncology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 16. *Nephrology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 17. *Neurology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 18. *Ophthalmology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 19. *Orthopedics:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 20. *Otorhinolaryngology/Otolaryngology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	21. *Urology:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 22. *Psychiatrists:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 23. *Physicians and LMHPs who specialize in pregnancy-related and postpartum depression or related mental health disorders and pregnancy-related:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 24. *Physicians and LMHPs who specialize in pregnancy-related and postpartum substance use disorders:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles* 25. *Specialty Dental Services* a. *Travel distance shall not exceed 60 miles one-way from the enrollee's place of residence for at least 75% of enrollees.*	
	Evidence as submitted by the MCE: • Q1 & Q2 220 Network Adequacy • Q3 & Q4 220 Network Adequacy	
Licensed Mental Health Specialists		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract	26. *Behavioral Health Specialist: Advanced Practice Registered Nurse (APRN) with a behavioral health specialty; Medical or Licensed Psychologist; Licensed Clinical Social Worker (LCSW)* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	**Evidence as submitted by the MCE:** • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	27. *PRTF; PRTF Addiction (American Society of Addiction Medicine [ASAM] Level 3.7); PRTF Other Specialization* a. *Rural and Urban Parishes: 200 miles* **Evidence as submitted by the MCE:** • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	Y ☒ N ☐ NA ☐
Substance Abuse and Alcohol Abuse Center - Outpatient		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	28. *ASAM Level 1:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 29. *ASAM Level 2.1:* a. *Rural Parishes: 30 miles* b. *Urban Parishes: 15 miles* 30. *ASAM Level 2WM:* a. *Rural Parishes: 60 miles* b. *Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	
Substance Use Residential Treatment Facilities (adult)		
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	31. *ASAM Levels 3.1* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 32. *ASAM Levels 3.3* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 33. *ASAM Levels 3.5* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 30 miles* 34. *ASAM Levels 3.2-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 35. *ASAM Level 3.7* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 36. *ASAM Level 3.7-Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
	Evidence as submitted by the MCE: • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	
Substance Use Residential Treatment Facilities (pediatric)		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218 Contract MCO Contract: Amendment F PAHP Contract: None PIHP Contract: None	37. *ASAM Level 3.1* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 38. *ASAM Level 3.2 Withdrawal Management* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles* 39. *ASAM Level 3.5* *a. Rural Parishes: 60 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☒ NA ☐
	Evidence as submitted by the MCE: • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	
Psychiatric Inpatient Hospital Services		
42 CFR §438.207(a) 42 CFR §438.207 (b)(1-2) 42 CFR §457.1218	40. *Hospital, Free Standing Psychiatric Unit; Hospital, Distinct Part Psychiatric Unit* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 90 miles*	Y ☒ N ☐ NA ☐

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
Contract MCO Contract: Amendment F PAHP Contract: NA PIHP Contract: NA	**Evidence as submitted by the MCE:** • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	
Behavioral Health Rehabilitation Services		
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. *Mental Health Rehabilitation (MHR) Agency (Legacy MHR); Behavioral Health Rehab Provider Agency (Non-Legacy MHR)* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	Y ☐ N ☒ NA ☐
Behavioral Health Specialists		
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: 6.3.1.1.1.1; 6.3.1.1.1.2	42. *For the PIHP, behavioral health specialists (i.e., psychologists, medical psychologists, Advanced Practiced Registered Nurses or Clinical Nurse Specialists, or LCSWs) and to psychiatrists* *a. Rural Parishes: 30 miles* *b. Urban Parishes: 15 miles* **Evidence as submitted by the MCE:** • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	Y ☐ N ☐ NA ☒

Standard V—Access Standards: Time/Distance Checklist		
Reference	**Required Components**	
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. *For the PIHP, specialized behavioral health outpatient non-MD services (excluding behavioral health specialists):* *a. Rural Parishes: 90 miles* *b. Urban Parishes: 60 miles*	Y ☐ N ☐ NA ☒
	Evidence as submitted by the MCE: • 328 Q1 2024 • 328 Q2 2024 • 328 Q3 2024 • 328 Q4 2024	

Standard VI—Coordination and Continuity of Care

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Care Coordination and Services		
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).		
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. a. The member is provided information on how to contact their designated person or entity. 42 CFR §438.208(b)(1) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.1; 2.8.1.4.2 PAHP Contract: None PIHP Contract: 7.2.5.2	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or member notice • Primary care provider (PCP) assignment algorithm • Screenshot of member identification (ID) card • Screenshot of fields designating the assigned PCP and assigned case manager • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 1. – UHC CM Process Policy 002 ▪ Page 2 ▪ Page 11, Section H #5 and #6. • 1a. – UHC CM Process Policy 002	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	▪ Page 11, Section H #3 and #4 ▪ Page 4, Section C2, C3 ▪ Page 8, Section #4 – UHC Member Handbook ▪ Pages 15 and 17 – LA UHC C&S Coord Cont Transition of BH Care ▪ Page 5, B #5. – Member Enrollment and Disenrollment Policy PCP ▪ Page 1 – Member Unable to Reach Notice – UHC PCP Reassignment – Member's Identification card x 3 – System Screenshot of PCP and Care Manager Assignment – UHC 2024 CM Program Description. **Additional Documentation:** • Member Enrollment and Disenrollment (Page 5)	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHC C&S LA) has established a tiered Case Management program tailored to individual member needs, including those with special health care needs. This program ensures members have an ongoing source of care and a designated care coordinator, supported by a POD Care Team model that considers regional and demographic factors. Members are contacted through multiple outreach attempts, and if unreachable, are sent written information on how to engage with their case manager. Upon successful contact, members receive education on available services, rights, and how to access or opt out of case management. These efforts support the deliverable by ensuring each member is informed of and connected to a designated person or entity responsible for coordinating their care. UHC C&S LA ensures members have access to an ongoing source of care by helping them select and maintain a		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
Primary Care Provider (PCP). Members can choose a PCP through various channels, including online tools, printed directories, or by contacting Member Services. This process supports the deliverable by ensuring each member has a designated provider and receives clear guidance on how to reach them for coordinated care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE coordinates the services the MCE furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. b. With the services the member receives from any other MCO, PIHP, or PAHP. c. With the services the member receives in fee-for-service (FFS) Medicaid. d. With the services the member receives from community and social support providers. MCO: a. *Coordinate care between network PCPs and specialists, including specialized behavioral health providers;* b. *Coordinate care for out-of-network services, including specialty care services;* c. *Coordinate Contractor-provided services with services the Enrollee may receive from other health care providers;* d. *Coordinate with the court system and State child-serving agencies with regard to court- and agency-*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Transition of care program • Workflow for coordinating with other MCOs/ PIHPs/PAHPs • Workflow for coordinating with FFS • Workflow for coordinating with community and social support resources • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 2.a. – UHC CM Process Policy 002 ▪ Page 8, Section #4, First Sentence ▪ Page 1, Bullet #12. • 2.b. – UHC CM Process Policy 002 ▪ Page 14, Section L #2.	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
involved youth, to ensure that appropriate services can be accessed. PAHP: a. Coordination with the enrollee's MCO: i. *for oral health issues exceeding the coverage of the Contract;* ii. *for transportation to and from covered dental services; and* iii. *regarding value-added dental benefits offered by the enrollee's MCO.* PIHP: a. *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.* b. *Coordinate care for out-of-network services.* c. *Coordinate Contractor provided services with services the member may receive from other primary or behavioral healthcare providers.* d. *Coordinate timely with Integrated Medicaid Managed Care Programs and the member's family following an inpatient, psychiatric residential treatment facility (PRTF), nursing facility, or other residential stay for members when a return to home placement is not possible.* 42 CFR §438.208(b)(2) 42 CFR §457.1230(c) 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	• 2.c. – UHC CM Process Policy 002 ▪ Page 14, Section L #2. – UHC Care Coor with Medicaid Policy 043 ▪ Page 1, III, Bullet #5. • 2.d. – UHC CM Process Policy 002 ▪ Page 8, Section #4 ▪ Page 13, Section I #7 – UHC Integration of Phys. BH Health Policy 006 ▪ Page 1, Section IV, B 3. – UHC Care Model 2,0 Job Aide ▪ Pages 29 and 38 • MCO 2a. – UHC CM Process Policy 002 ▪ Page 1, Bullet 12 and 13 ▪ Page 3, Section B – UHC Mgmt of Care Transition Policy 021 ▪ Pages 2 and 3, #5 b. ▪ Page 4, b and c • MCO 2b. – UHC CM Process Policy 002 ▪ Page 1, Bullets 12 and 13. • MCO 2c.	

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
PIHP Contract: 7.2.4; 7.2.5.5; 7.2.5.6; 7.2.5.7	– UHC CM Process Policy 002 ▪ Page 1, Bullets 12 and 13 • MCO 2d. – UHC SHCN Membership Policy 002.4 ▪ Page 1, Section I. and II. – UHC CM Process Policy 002 ▪ Pages 3 and 4, C #1, 2, 3, and 4. • PAHP PORTION: DENTAL - N/A – LA UHC C&S Coord Cont_Transition of BH Care – Transition of Care Program - UHC NCM LA 021 Policy ▪ Page 1 – Workflow for coordinating with other MCOs -UHC LA 009.1.1 Transition of Care Coor. Job Aid ▪ Page 1 – Workflow for coordinating with community and social support resources – LA Care Model Job Aid ▪ Page 29 – UHC 2024 CM Program Description	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHC C&S LA) coordinates care across all settings and providers to ensure continuity and quality of services for members. This includes discharge planning and transitional case management for institutional stays, as well as coordination with PCPs, specialists, behavioral health providers, and community-based services. UHC C&S LA collaborates with other MCOs, PIHPs, and FFS Medicaid programs to share care plans and utilization data, ensuring seamless transitions and avoiding duplication of services. Case managers engage members, providers, and social support networks to address medical and social needs,		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
including scheduling follow-ups and connecting members to community resources. These efforts directly support the deliverable by ensuring coordinated, member-centered care across all systems and service providers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual case management performance evaluation (CMPE) file review demonstrated overall compliance with service coordination.		
Required Actions: No action required.		
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. MCO: a. *The MCO shall provide procedures and criteria for making referrals and coordinating care with behavioral health and primary care providers and agencies that will promote continuity of care. These procedures shall address Enrollees with co-occurring medical and behavioral conditions, including children with special health care needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services.* 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.2.7; 2.8.2.8 PAHP Contract: None PIHP Contract: 7.2.5.8	**HSAG Required Evidence:** **Evidence as Submitted by the MCE:** • 3. – UHC CM Process Policy 002 ▪ Page 3, IV, A #4 – UHC NCM LA 006 Policy ▪ Page 1, Section IV, B #1 and #2 • 3a. – UHC CM Process Policy 002 ▪ Page 3, B – UHC CM and SC Collaboration Policy 006.1 ▪ Page 1, Purpose – LA UHC C&S Coord Cont_Transition of BH Care	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) coordinates care across physical and behavioral health systems by sharing member assessments and clinical data with the Louisiana Department of Health (LDH) and other entities, as appropriate. The Health Plan conducts comprehensive assessments for members regardless of age with special health care needs (SHCNs) and ensures this information is accessible to relevant providers to support integrated, non-duplicative care. Procedures are in place to coordinate		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
services across primary care, behavioral health, and community-based providers, particularly for members with complex or co-occurring conditions and those with Special Healthcare Needs. These practices fulfill the deliverable by preventing duplication of assessments and promoting coordinated service delivery across systems.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Information Sharing		
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 MCO: a. *Upon written request* 42 CFR §438.208(b)(4) 42 CFR §457.1230(c) MCO Contract: 2.8.1.4.6 PAHP Contract: None PIHP Contract: 7.2.5.8; 7.2.6.1.2	**HSAG Required Evidence:** • Policies and procedures • Workflow for sharing assessment results with the State • Workflow for sharing assessment results with other MCOs/PIHPs/PAHPs • Care management program description • Three examples of sharing assessment results with the State and/or appropriate MCOs, PIHPs, and/or PAHPs **Evidence as Submitted by the MCE:** • 4. – UHC Trans. of Care Coor Policy 009.1 ▪ Page 1, Sections II and III. – UHC Integration of Phys BH Health Policy 006 ▪ Page 1, Section IV. B 1 and 2 – UHC Interdisciplinary Case Conf. Policy 003 ▪ Pages 1 and 2, Section V. B, C, and D. – UHC 2024 CM Program Description.	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) has established procedures to share member assessment and care planning information with the Louisiana Department of Health (LDH) or other health entities upon written request, in compliance with HIPAA regulations. This includes sharing prior authorizations, case management details, and relevant clinical data to ensure continuity of care and prevent duplication of services. Transition coordinators and case managers facilitate communication between providers during transitions in coverage or care. Interdisciplinary case conferences and care coordination efforts ensure that all involved parties are informed of the member's needs and treatment goals. These practices fulfill the deliverable by supporting seamless care transitions and reducing redundant assessments.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.208(b)(5) 42 CFR §457.1230(c) 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	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Provider materials, such as the provider manual and provider contract • Results of medical record reviews (MRR) or other oversight mechanisms for monitoring provider health record practices **Evidence as Submitted by the MCE:** • 5. – Member Handbook ▪ Page 8 – Provider Manual ▪ Pages 82 and 84 – UHC 2024 MRR Policy ▪ Page 1, Section IV. – MMR Reports for Q1, Q2, Q3, and Q4	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	– Sample of physician contract and small group provider contract – Provider Record Audit Tool – UHC 2024 CM Program Description.	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) requires all providers to maintain complete, organized, and confidential medical records in accordance with professional standards and applicable regulations. Providers must ensure records are accessible, retained for the required duration, and shared appropriately to support continuity and quality of care. Medical record reviews are conducted regularly to assess compliance, and corrective actions are implemented when standards are not met. Members are entitled to access their records, and providers must coordinate documentation across physical and behavioral health services. These practices fulfill the deliverable by ensuring that providers maintain and appropriately share member health records to support integrated, high-quality care.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.208(b)(6) 42 CFR §457.1230(c) 45 CFR Part 160 45 CFR Part 164, Subparts A and E 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	**HSAG Required Evidence:** • Policies and procedures • Care management program description **Evidence as Submitted by the MCE:** • 6. – UHC Care Model 2.0 Job Aide ▪ Page 8 – LA UHC C&S Coord Cont_Transition of BH Care – UHC 2024 CM Program Description. **Additional Documentation:** • Identification and Authentication Policy	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) ensures member privacy is protected during care coordination by adhering to HIPAA and applicable federal and state confidentiality regulations, including 45 CFR Parts 160 and 164. During initial outreach, care managers validate member identity and explain the case management program while maintaining strict privacy protocols. Clinical information is shared only as appropriate and in compliance with privacy standards, ensuring both primary care and behavioral health providers have access to relevant data for coordinated care. Providers are required to maintain and share health records in accordance with professional and legal standards. These practices support the deliverable by safeguarding member privacy throughout the care coordination process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Initial Health Risk Screening		
7. The MCE makes a best effort to conduct an initial screening of each member's needs within MCO: 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. *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.* PAHP: a. *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.*	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Initial screening template • Initial screening tracking and monitoring mechanisms and subsequent results/reports • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 7a. – UHC CM Process Policy 002 ▪ Page 2 Section IV, A. ▪ Page 2 Section A, #1 ▪ Page 3 Section A, #3 and #4. – Initial Screening Template - LA Healthcare Needs Assessment Optum BH	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.208(b)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.2.2 PAHP Contract: 2.4.5.3.1 PIHP Contract: NA	– Initial Screening Template – LA Health Needs Assessment Care Model – UHC Initial Screening Tracker Monitoring – UHC 2024 CM Program Description. • PAHP PORTION: DENTAL – N/A	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) conducts a Health Needs Assessment (HNA) for each new member within 90 calendar days of enrollment, using a standardized tool developed by LDH. The HNA identifies medical, behavioral, and social needs, including those requiring short-term care coordination or case management. If initial outreach is unsuccessful, UHCCP LA documents at least three follow-up attempts on different days and times. HNA results are shared with the member's Primary Care Provider and LDH, as appropriate. These procedures fulfill the deliverable by demonstrating best efforts to assess member needs early and coordinate care accordingly.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that UHC had policies, procedures, and mechanisms to conduct the initial health needs assessment (HNA); however, results from the virtual CMPE file review demonstrated noncompliance with timely completion of the initial HNA.		
Required Actions: 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.		
Comprehensive Assessment		
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	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Documentation (e.g., program description, quality strategy, etc.) defining members with special healthcare needs and members needing LTSS	☐ Met ☒ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
member that require a course of treatment or regular care monitoring. a. The assessment mechanisms use appropriate providers or individuals meeting LTSS services coordination requirements of the State or MCO as appropriate. PAHP: a. *The PAHP shall maintain written procedures for identifying, assessing, and implementing interventions for enrollees with complex health issues, I/DD, high service utilization, intensive dental care needs, or who consistently access services at the highest level of care.* 42 CFR §438.208(c)(2) 42 CFR §457.1230(c) MCO Contract: 2.7.3.1 PAHP Contract: 2.4.6.2.2 PIHP Contract: 7.1.4.1	• Comprehensive assessment template • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 8. – UHC Risk Strat Process Policy 012 ▪ Pages 2 and 3, #4, a-l – UHC CM Process Policy 002 ▪ Page 3, B, B3 and B4 – LA UHC C&S Coord Cont_Transition of BH Care • 8a. – UHC Risk Strat Process Policy 012 ▪ Page 3, #6 a. – UHC Case Mgmt Process Policy 002 ▪ Page 2, III. Section Policy. – Define Mbrs with SHCN – UHC SHCN Membership Policy 002.4 – LA Core Assessment – Pediatric Core 3.0 Assessment – UHC 2024 CM Program Description	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) uses claims data, predictive modeling, and other sources to identify members with special health care needs (SHCN). Identified members receive a comprehensive assessment by qualified case managers within 90 days, focusing on ongoing conditions that require treatment or monitoring. The assessment process includes risk stratification based on clinical, behavioral, and social factors, and ensures no eligible member is excluded. UHCCP LA also shares		

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Requirement	**Supporting Documentation**	**Score**
treatment plans and coordinates care across providers and state agencies. These mechanisms meet the deliverable by ensuring timely, thorough assessments using qualified personnel to support individualized care planning.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that UHC had policies, procedures, and mechanisms to conduct the initial comprehensive assessment, timely in-person reassessments, and annual reassessments; however, results from the CMPE file review demonstrated noncompliance with completion of timely in-person reassessments and annual reassessments.		
Required Actions: The MCE must conduct an in-person quarterly reassessment and annual reassessment of each member's needs as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the in-person assessment and annual reassessment on at least three different occasions, at different times of the day and on different days of the week and/or provide documentation of the member's refusal to complete the reassessment in person. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of in-person quarterly reassessments and annual reassessments. This process must include reassessment monitoring, defined frequency of oversight, tools/reports being utilized, and expectation for staff follow up. Case management system flags, queues, or reports that monitor these requirements should be considered.		
Treatment/Service Plan		
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. 42 CFR §438.208(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.1 PAHP Contract: None PIHP Contract: 7.1.4.3	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Person centered treatment plan template • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 9. – UHC CM Process Policy 002	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	▪ Page 1, Section Purpose/Scope, Bullets #3 and #4 ▪ Page 2, Section III ▪ Page 12, Section l, #1 – LA UHC C&S Coord Cont_Transition of BH Care – Care Plan Template – POC BH Template – LA BH POC Process – UHC 2024 CM Program Description	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) develops individualized, person-centered Plans of Care (POCs) for all members eligible for case management, including identified with special health care needs (SHCN). These POCs are based on comprehensive assessments and are designed to coordinate medical, behavioral, and social services across care settings. When members receive services from other state agencies, UHCCP LA collaborates with those entities to ensure integrated planning. The POC is actively monitored and updated to reflect changes in the member's condition or care needs. These practices fulfill the deliverable by ensuring that members with complex needs receive coordinated, ongoing care through structured service planning.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance with the timely completion of a plan of care (POC).		
Required Actions: No action required.		
10. The treatment or service plan is: a. Developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member.	**HSAG Required Evidence:** • Policies and procedures • Case management program description • Staff qualifications for developing care plans and service plans (e.g., job description) • Service plan approval process	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
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. c. Approved by the MCE in a timely manner, if this approval is required by the MCE. d. In accordance with any applicable State quality assurance and utilization review standards. 42 CFR §438.208(c)(3)(i-iv) 42 CFR §441.301(c)(1-2) 42 CFR §457.1230(c) MCO Contract: 2.7.8.2 PAHP Contract: None PIHP Contract: 7.1.4.3	• Mechanisms to actively involve the member and the member's formal and informal supports in the development of the treatment plan • 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 • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 10a. N/A • 10b. – UHC CM Process Policy 002 ▪ Page 12, I # 2 and #3 ▪ Pages 12 and 13, #6 – UHC Case Mgmt Orientation Perf. Policy 010 ▪ Page 1, Section IV, 2 ▪ Page 1, # 3. a. b. and c. – UHC 2024 CM Program Description • 10c. N/A	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) develops individualized, person-centered Plans of Care (POCs) for members eligible for case management, including those identified with special health care needs. These plans are created by trained case managers in collaboration with the member, their interdisciplinary care team, and relevant providers, including behavioral health specialists when applicable. The POC incorporates all medically necessary services, care coordination, and community supports, and is documented and monitored through the case management system. Case managers are trained in person-centered planning and follow state and federal requirements. These practices ensure the treatment plan meets the deliverable by being member-driven, clinically informed, and compliant with quality and utilization standards.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Results from the virtual CMPE file review demonstrated overall compliance in development of POCs that are person-centered and include goals, risks, behavioral health, and supports.		
Required Actions: 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). 42 CFR §438.208(c)(3)(v) 42 CFR §441.301(c)(3) 42 CFR §457.1230(c) MCO Contract: 2.7.8.4 PAHP Contract: None PIHP Contract: Glossary	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Care plan and service plan review and revision tracking mechanism • HSAG will also use the results of the case file reviews **Evidence as Submitted by the MCE:** • 11. – UHC CM Process Policy 002 ▪ Page 12, I, # 4. – LA UHC C&S Coord Cont_Transition of BH Care – UHC Care Model Job Aid ▪ Care Plan Tracking Mechanism – Pages 15 & 16 – POC BH Template – Care Plan Template – LA BH POC Process – UHC 2024 CM Program Description	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) ensures that each member's Plan of Care (POC) is reviewed and updated at least annually, or sooner if there is a significant change in the member's needs or at the member's request. The reassessment process is person-centered and led by the case manager with input from the member and their interdisciplinary care team.		

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
For members receiving Specialized Behavioral Health Services (SBHS), behavioral health treatment plans are integrated into the overall POC to ensure coordinated care. All updates are documented and reflect current functional needs and service requirements. These practices meet the deliverable by ensuring timely, member-driven revisions to the treatment plan in accordance with 42 CFR §441.301(c)(3).		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for the desk review validated that UHC had policies, procedures, and mechanisms to conduct timely POC updates; however, results from the CMPE file review demonstrated noncompliance with completion of timely POC updates.		
Required Actions: The MCE must conduct timely POC updates as required by assessed tier level, including subsequent attempts if the initial attempt to contact the member is unsuccessful. Additionally, the MCE shall attempt to conduct, and document its efforts to conduct, the POC update on at least three different occasions, at different times of the day and on different days of the week and/or provide documentation of the member's refusal to complete the POC update in person. Furthermore, the MCE must evaluate its oversight process to ensure the timely completion of timely POC updates. This process must include POC update 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.		
Direct Access to Specialists		
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. 42 CFR §438.208(c)(4) 42 CFR §457.1230(c) MCO Contract: 2.9.12.7 PAHP Contract: 2.4.6.2.1.2 PIHP Contract: 7.1.4.1	**HSAG Required Evidence:** • Policies and procedures • Care management program description • Member materials, such as the member handbook or benefits grid • Provider materials, such as the provider manual or provider contracts **Evidence as Submitted by the MCE:** • 12. – Member Handbook ▪ Page 22 and Pages 28-42. – Provider Manual	☒ Met ☐ Not Met ☐ NA

Standard VI—Coordination and Continuity of Care		
Requirement	**Supporting Documentation**	**Score**
	▪ Pages 2, 16, and 19. – UHC 2024 CM Program Description	
MCE Description of Process: UnitedHealthcare Community & State Louisiana (UHCCP LA) ensures that members with special health care needs (SHCN) who require ongoing treatment or monitoring have direct access to specialists. While referrals are not required, members are encouraged to coordinate care with their primary care provider (PCP) and specialists. The case management program includes support from community health workers and care teams who assist with referrals and appointment coordination for complex needs. UHCCP LA also provides mechanisms for timely access to specialty care and supports providers in locating appropriate specialists. These practices meet the deliverable by ensuring members can access needed specialty services without unnecessary barriers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VI—Coordination and Continuity of Care							
Total	Met	=	9	X	1	=	9
	Not Met	=	3	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	12	**Total Score**		=	9

Total Score ÷ Total Applicable	=	**75%**

Standard VII—Coverage and Authorization of Services

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
Coverage		
1. The MCE: a. Identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer. 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. c. Ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. 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) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and benefits grid • Utilization Management (UM) program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • Clinical Review Criteria Policy, page 3 • 2024 UHC UMPD • LA Coverage Guidelines and Criteria	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Clinical Review Criteria Policy describes how the Utilization Management (UM) program uses evidence-based, clinical review criteria to support clinical review decisions for UM programs. The clinical review process is applied consistently in accordance with written procedures and with consideration for individual consumer needs. The Clinical Review Criteria Policy page 3 describes how the MCE identifies, defines, and specifies the amount, duration, and scope of each service that the MCE is required to offer, 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		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
set forth in 42 CFR §440.230, and for members under the age of 21, as set forth in 42 CFR §441 Subpart B, and ensures each service is sufficient in the amount, duration, and scope to reasonably achieve its purpose. The 2024 UHC Utilization Management Program Description (UMPD) SECTION B – PROGRAM STRUCTURE OVERSIGHT describes the UM Program's development, implementation, oversight, and evaluation which involves UHC senior-level medical directors. The LA Coverage Guidelines and Criteria describes the Community Plan of Louisiana Medical & Drug Policies Terms and Conditions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.210(a)(3)(ii) 42 CFR §440.230(c) 42 CFR §457.1230(d) MCO Contract: 2.4.1.3 PAHP Contract: 2.5.1.1 PIHP Contract: 4.1.8	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • Clinical Review Criteria Policy, page 3 • 2024 UHC UMPD • LA Coverage Guidelines and Criteria	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Clinical Review Criteria Policy describes how the Utilization Management (UM) program uses evidence-based, clinical review criteria to support clinical review decisions for UM programs. The clinical review process is applied consistently in accordance with written procedures and with consideration for individual consumer needs. The Clinical Review Criteria Policy page 3 describes how the MCO shall ensure that Covered Services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished, MCO shall not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Enrollee. [42 CFR §438.210(a)(3)]. The 2024 UHC UMPD Section XIV. QUALITY PROCESS IMPROVEMENT describes the Quality process, which is a structured, disciplined approach to maintain consistent application of UM processes. The LA Coverage Guidelines and Criteria describes the Community Plan of Louisiana Medical & Drug Policies Terms and Conditions.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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: MCO, PAHP, and PIHP: a. The services furnished can reasonably achieve their purpose. MCO and PIHP: 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. 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. 42 CFR §438.210(a)(4) 42 CFR §441.20 42 CFR §440.230(d) 42 CFR §457.1230(d) MCO Contract: 2.4.1.4 PAHP Contract: 2.5.1.2 PIHP Contract: 4.1.10	**HSAG Required Evidence:** • Policies and procedures • Utilization management plan • Member materials, such as the member handbook • Coverage guidelines/criteria **Evidence as Submitted by the MCE:** • Clinical Review Criteria Policy, page 3 • 2024 UHC UMPD • LA Coverage Guidelines and Criteria **Additional Documentation:** • Member Handbook, p28-42, & 43-55	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Clinical Review Criteria Policy describes how the Utilization Management (UM) program uses evidence-based, clinical review criteria to support clinical review decisions for UM programs. The clinical review process is applied consistently in		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
accordance with written procedures and with consideration for individual consumer needs. The Clinical Review Criteria Policy page 3 describes in accordance with 42 CFR §438.210(a)(4), how the MCO may place appropriate limits on a service that are: On the basis of criteria applied under the State Plan, such as medical necessity; or for the purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose; the services support Enrollees with ongoing or chronic conditions and are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports; and that family planning services are provided in a manner that protects and enables the Enrollee's freedom to choose the method of family. The 2024 UHC UMPD Section IX. CLINICAL REVIEW CRITERIA, DEVELOPMENT AND APPROVAL describes clinical review criteria and determinations. The LA Coverage Guidelines and Criteria describes the Community Plan of Louisiana Medical & Drug Policies Terms and Conditions.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. The MCE specifies what constitutes "medically necessary services" in a manner that: 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 b. Addresses the extent to which the MCE is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development.	**HSAG Required Evidence:** • Policies and procedures • UM program description • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • Clinical Review Criteria Policy, page 4 • 2024 UHC UMPD • Provider Handbook **Additional Documentation:** • Member Handbook, p28-42, & 43-55	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
iii. The ability for a member to attain, maintain, or regain functional capacity. 42 CFR §438.210(a)(5) MCO Contract: 2.4.1.6 PAHP Contract: 2.5.2.6; 2.5.2.7 PIHP Contract: 4.1.10; 4.1.11		
MCE Description of Process: The Clinical Review Criteria Policy describes how the Utilization Management (UM) program uses evidence-based, clinical review criteria to support clinical review decisions for UM programs. The clinical review process is applied consistently in accordance with written procedures and with consideration for individual consumer needs. Page 4 of the Clinical Review Criteria Policy defines what constitutes medically necessary services in a manner that is no more restrictive than that used by the State Medicaid program. This includes both quantitative and non-quantitative treatment limits, as specified in State statutes, regulations, the State Plan, and other State policies. The Clinical Review Criteria Policy also addresses the extent to which the MCE is responsible for covering services that address: The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability, the ability for a member to achieve age-appropriate growth and development, and the ability for a member to attain, maintain, or regain functional capacity. The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. The UMPD section B Program Structure Oversight describes the UM Program's development, implementation, oversight, and evaluation which involves UHC senior-level medical directors.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not have a policy or any documentation that specified what constitutes medically necessary services.		
Required Actions: The MCE must develop a policy or a document that specifies what constitutes "medically necessary services" in a manner that: 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 b. Addresses the extent to which the MCE is responsible for covering services that address: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
ii. The ability for a member to achieve age-appropriate growth and development. iii. The ability for a member to attain, maintain, or regain functional capacity.		
Authorization of Services		
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. 42 CFR §438.210(b)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.3.6.1 PAHP Contract: 2.5.2.1.1.5 PIHP Contract: 7.5.2.1	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • List of delegated entities performing utilization management • Delegated written contract (for entities responsible for delegated UM functions) • Delegation oversight of policies and procedures (e.g., audit results) **Evidence as Submitted by the MCE:** • Initial Clinical Review Policy, page 5 • 2024 UHC UMPD • LA Coverage Guidelines and Criteria **Additional Documentation:** • Optum Healthcare Solutions (Optum Physical Health) Contract • eviCORE Contract • Optum Behavioral Health Contract • OPH 2024 Q1 IAP Worksheet	☒ Met ☐ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	• OPH 2024 Q2 IAP Worksheet (Annual) • OPH 2024 Q3 IAP Worksheet • OPH 2024 Q4 IAP Worksheet • eviCORE 2024 Annual Case File Review • 2024 OBH Annual C&S • OBH 2024 Q2 Quarterly IAP Worksheet • OBH 2024 Q3 IAP Worksheet • OBH 2024 Q4 Quarterly IAP Worksheet	
MCE Description of Process: The Initial Clinical Review Policy page 5 describe the MCE has in place, and follows, written policies and procedures for the processing of requests for initial and continuing authorization of services. The 2024 UHC UMPD outlines philosophy, structure, and standards that guide medical management, utilization management, and utilization review responsibilities. The LA Coverage Guidelines and Criteria define the terms and conditions for the Community Plan of Louisiana Medical & Drug Policies.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
6. The MCE has in effect mechanisms to ensure consistent application of review criteria for authorization decisions. 42 CFR §438.210(b)(2)(i) 42 CFR §457.1230(d) MCO Contract: 2.12.4.1; 2.12.6 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Coverage guidelines/criteria • Results of inter-rater reliability (IRR) activities **Evidence as Submitted by the MCE:** • Clinical Review Criteria Policy, pages 5 and 6 • 2024 UHC UMPD • LA Coverage Guidelines and Criteria	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 2024 LA IRR Scores **Additional Documentation:** • IRR Narrative • 2024 OBH IRR Aggregate Report • OPH 2024 Q2 IAP Worksheet (Annual)—DPM Details tab, question OQ6 and OQ9 • eviCORE Annual Interrater Reliability Summary 2024	
MCE Description of Process: The Clinical Review Criteria Policy describes how the Utilization Management (UM) program uses evidence-based, clinical review criteria to support clinical review decisions for UM programs. The clinical review process is applied consistently in accordance with written procedures and with consideration for individual consumer needs. Pages 5 and 6 of the Clinical Review Criteria Policy describe the mechanisms used to ensure consistent application of review criteria for authorization decisions. The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review responsibilities. SECTION B – Program Structure Oversight and SECTION C – Programs, Reviews & Services describe the mechanisms used to ensure consistent application of review criteria for authorization decisions. SECTION E – Service Initiatives/Patient Safety and SECTION XIV – Quality Process Improvement explain the participation in inter-rater reliability (IRR) exercises at least annually. These exercises help ensure consistent application of benefit document language and clinical review criteria. Refer to the 2024 LA IRR Scores to view the results. The LA Coverage Guidelines and Criteria document defines the terms and conditions for the Community Plan of Louisiana Medical & Drug Policies.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that the MCE develop an overarching policy/procedure that specifies its interrater reliability (IRR) process.		
Required Actions: No action required.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
7. The MCE consults with the requesting provider for medical services when appropriate. 42 CFR §438.210(b)(2)(ii) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.2.1.1.7 PIHP Contract: 7.5.2.2	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider materials, such as the provider manual, provider communications • Three case examples of peer-to-peer consults **Evidence as Submitted by the MCE:** • Initial Adverse Determination Notice Policy, page 4 • 2024 UHC UMPD **Additional Documentation:** • UCSMM 06 15 Peer Clinical Review • A246028751 Peer to Peer Example 1 • A245905150 Peer to Peer Example 2 • A246364713 Peer to Peer Example 3	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: The Initial Adverse Determination Notice Policy describes how the utilization management program tracks notices of adverse determination resulting from administrative or clinical review. Written notice of an adverse determination is given to the provider who requests coverage and/or provides the service as well as the consumer. Initial Adverse Determination includes consultation with the requesting provider for medical services when appropriate. The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review. SECTION C – Programs, Reviews & Services, VII outlines UHCCP consults with the requesting provider for medical services when appropriate.		
HSAG Findings: 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		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
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.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
8. The MCE authorizes LTSS based on a member's current needs assessment and consistent with the person-centered service plan. 42 CFR §438.210(b)(2)(iii) MCO Contract: NA PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • Authorization workflow for LTSS • UM program description • Coverage guidelines/criteria • Three examples of authorized LTSS and copies of the corresponding person-centered service plans **Evidence as Submitted by the MCE:** • NA	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: NA		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
9. The MCE ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical, behavioral health. MCO: a. *The Contractor shall ensure that only licensed clinical professionals with appropriate clinical expertise in the*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Job descriptions for UM decision makers • HSAG will also use the results of the Service Authorization Denial File Review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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. PAHP: a. *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.* 42 CFR §438.210(b)(3) 42 CFR §457.1230(d) MCO Contract: 2.12.5.2 PAHP Contract: 2.5.6.1.1 PIHP Contract: 7.5.2.3	**Evidence as Submitted by the MCE:** • Peer Clinical Review Policy • 2024 UHC UMPD • CCR Medical Director Job Description • CCR Nurse Job Description • CCR Physician Assistant Job Description • Certified Pharmacy Technician Job Description • Clinical Pharmacist-Medication Clinical Reviewer • ICM LPN LVN Job Description • ICM Medical Director Job Description • ICM RN Job Description • ICM Sr Medical Director Job Description • ICM Sr RN Job Description • National Medical Director Job Description • National Medical Director VP Job Description • Pharmacy Clinical Pharmacist Job Description • Pharmacy Technician Certified Medical Job Description • Service Auth Denial File	
MCE Description of Process: The Peer Clinical Review Policy describes how to ensure that adverse determination resulting from clinical review is conducted only by appropriately licensed health professionals. Peer Clinical Review Policy page 4 states 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.		

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Requirement	**Supporting Documentation**	**Score**
Job descriptions for the CCR Medical Director, CCR Nurse, CCR Physician Assistant Job Description, Certified Pharmacy Technician, Clinical Pharmacist-Medication Clinical Reviewer, ICM LPN LVN, ICM Medical Director, ICM RN, ICM Sr Medical Director, ICM Sr RN, National Medical Director, National Medical Director VP, Pharmacy Clinical Pharmacist, and Pharmacy Technician Certified Medical describe purposes and qualifications of staff involved in the UM process. The 2024 UHC UMPD SECTION D – DEPARTMENTAL ROLES & RESPONSIBILITIES describes the staffing model that supports the UMPD which consists of clinical, non-clinical, and administrative personnel. Service Auth Denial File - A261004747		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notice of Adverse Benefit Determination		
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. MCO: a. *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.* PIHP: a. *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*	**HSAG Required Evidence:** • Policies and procedures • UM program description • Provider notice template • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Adverse Determination Notice Policy, page 4 • 2024 UHC UMPD • LA IP ADMIN LATE NOTIF ONLY Template • LA RECON PRV Template	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.210(c) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.2 PAHP Contract: 2.5.7.1 PIHP Contract: 7.8.5.3.2		
MCE Description of Process: The Initial Adverse Determination Notice describes how the utilization management program tracks notices of adverse determination resulting from administrative or clinical review. Written notice of an adverse determination is given to the provider who requests coverage and/or provides the service as well as the consumer. To ensure timeliness, verbal and other acceptable electronic means of notice are used in addition to written notices. Page 4 of the Initial Adverse Determination Notice Policy details how the requesting provider is notified 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 MCE 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. 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 provider rendering the service is notified 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. The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. The MCE defines an adverse benefit determination (ABD) as: a. The denial or limited authorization of a requested service, including determinations based on the type or	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. 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. d. The failure to provide services in a timely manner, as defined by the State. 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. 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. 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. 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) MCO Contract: Glossary PAHP Contract: Glossary PIHP Contract: 11.2.1	**Evidence as Submitted by the MCE:** • Document Oversight and Adherence Policy, page 4	

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MCE Description of Process: Document Oversight and Adherence Policy page 4 defines an adverse benefit determination (ABD) as: 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, The reduction, suspension, or termination of a previously authorized service, 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, The failure to provide services in a timely manner, as defined by the State, 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, 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, and The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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: a. The ABD the MCE has made or intends to make. b. The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. 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),	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template with taglines • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Adverse Determination Notice Policy, page 4 • 2024 UHC UMPD • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template	☐ Met ☒ Not Met ☐ NA

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and right to request a State fair hearing consistent with 42 CFR §438.402(c). d. The procedures for exercising the rights specified in 42 CFR §438.402(b). e. The circumstances under which an appeal process can be expedited and how to request it. 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. g. The notice must be consistent with the requirements of 42 CFR §438.10. 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) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.4 PIHP Contract: 11.3.2	• LA NOA Template • LA Partial Denial NOA Template	
MCE Description of Process: The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review. The Initial Adverse Determination Notice Policy describes how the utilization management program tracks notices of adverse determination resulting from administrative or clinical review. Written notice of an adverse determination is given to the provider who requests coverage and/or provides the service as well as the consumer. To ensure timeliness, verbal and other acceptable electronic means of notice are used in		

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addition to written notices. Page 4 of the Initial Adverse Determination Notice Policy describes that 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 ABD the MCE has made or intends to make, The reasons for the ABD, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's ABD. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits, 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), The procedures for exercising the rights specified in 42 CFR §438.402(b), The circumstances under which an appeal process can be expedited and how to request it, 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, and The notice must be consistent with the requirements of 42 CFR §438.10. Submitted Templates - LA Chisholm Insufficient Information Template, LA Chisholm Member Approval Template, LA Chisholm MIOD Template, LA Chisholm NOA Template, LA NOA PDHC MMBPRV Template, LA NOA Template, LA Partial Denial NOA Template.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. Case file review results identified noncompliance with member notifications meeting the required reading grade level. UHC did not submit a policy to demonstrate the MCE's process for ensuring notices of ABD met required reading grade levels. **Recommendations:** 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.		
Required Actions: The MCE must develop a policy and procedure to ensure notices of ABD meet required reading grade levels.		
Timeframe for Decisions		
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. 42 CFR §438.210(d)(1) 42 CFR §438.404(c)(3)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.1.2 PAHP Contract: 2.5.7.2.1 PIHP Contract: 11.3.3.1.5	• HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Review Timeframes Policy, page 5 • 2024 UHC UMPD	
MCE Description of Process: The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review. The 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The Initial Review Timeframes Policy describes how required expedited and standard timeframes are maintained for reviews conducted on a prospective, concurrent, or retrospective basis. Page 5 further describes 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.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.210(d)(2)(i)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Service authorization log(s) within the time period under review • HSAG will also use the data from the universe file	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
42 CFR §438.404(c)(6) 42 CFR §457.1230(d) 42 CFR §457.1260(c)(3) MCO Contract: 2.12.6.2.1 PAHP Contract: 2.5.7.2.3 PIHP Contract: 11.3.3.1.8	• HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Review Timeframes Policy, page 5 • 2024 UHC UMPD **Additional Documentation:** • Tracking & Reporting Narrative • Initial Review Timeframes Policy (identified in virtual review)	
MCE Description of Process: The 2024 UHC UMPD outlines the philosophy, structure, and standards that guide medical management, utilization management, and utilization review. The 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The Initial Review Timeframes Policy describes how required expedited and standard timeframes are maintained for reviews conducted on a prospective, concurrent, or retrospective basis. Page 5 further explains 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.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. For standard and expedited authorization decisions, the MCE may extend the resolution time frame up to an additional 14 calendar days if: a. The member, or the provider, requests the extension; or	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms	☒ Met ☐ Not Met ☐ NA

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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. 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) 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	• Extension notice template • 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 • SHSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Review Timeframes Policy, page 5 • 2024 UHC UMPD **Additional Documentation:** • Tracking & Reporting Narrative • Initial Review Timeframes Policy (identified in virtual review)	
MCE Description of Process: The Initial Review Timeframes Policy describes how the Utilization Management (UM) program establishes and maintains required expedited and standard timeframes and extensions for administrative and clinical reviews conducted on a prospective, concurrent or retrospective basis. Staff members comply with the more stringent/restrictive of applicable accreditation, state/federal law, government contracts or programs. Additionally, the Initial Review Timeframes Policy page 5 describes that the Service Authorization determination may be extended up to an additional fourteen (14) additional Calendar Days if: The Enrollee, or the provider, requests the extension; or The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the Enrollee's interest. The 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements.		

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HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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: 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 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. 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) MCO Contract: None PAHP Contract: 2.5.7.3.1 PIHP Contract: 11.3.3.1.6	**HSAG Required Evidence:** • Policies and procedures • UM program description • Tracking and reporting mechanisms • Extension notice template(s) • Three case examples of authorizations with an extension, including the written notice of the extension • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • 2024 UHC UMPD **Additional Documentation:** • Tracking & Reporting Narrative • Initial Review Timeframes Policy (identified in virtual review)	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, the 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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17. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Social Security Act (SSA). a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. 42 CFR §438.210(d)(3) 42 CFR §457.1230(d) SSA §1927(d)(5)(A) MCO Contract: None PAHP Contract: NA PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • UM program description • Three examples of notice **Evidence as Submitted by the MCE:** • 2024 UHC UMPD • A261027454 drug auth • A261408846 drug auth • A261904321 drug auth	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy or documentation to demonstrate how UHC monitored the timeliness of outpatient drug authorization decisions by the PBM.		
Required Actions: The MCE must develop a policy and mechanisms to monitor the timeliness of the PBM's outpatient drug authorization decisions.		
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. 42 CFR §431.211 42 CFR §431.213 42 CFR §431.214 42 CFR §438.210(c)	**HSAG Required Evidence:** • Policies and procedures • UM program description • Advance ABD notice template(s) • Tracking and reporting mechanisms • Three case examples of advance notices, including the ABD notice and the effective date of decision	☐ Met ☒ Not Met ☐ NA

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42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.1 PIHP Contract: 11.3.3.1.1	• HSAG will also use the data from the universe file • HSAG will also use the results of the service authorization denial file review **Evidence as Submitted by the MCE:** • Initial Review Timeframes Policy, pages 6-7 • 2024 UHC UMPD • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA PARTIAL DENIAL NOA Template • A223354478 NABD Denial • A223467993 NABD Denial • A223733523 NABD Denial **Additional Documentation:** • UCSMM Initial Review Timeframes • UCSMM Initial Adverse Determination Notice	
MCE Description of Process: The Initial Review Timeframes Policy describes how the Utilization Management (UM) program establishes and maintains required expedited and standard timeframes and extensions for administrative and clinical reviews conducted on a prospective, concurrent or retrospective basis. Staff members will comply with the more stringent/restrictive of applicable accreditation, state/federal law, government contracts or programs. Additionally, the Initial Review Timeframes Policy page 6-7 the Contractor shall notify the Enrollee, in		

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writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Enrollee Grievances, Appeals and State Fair Hearings section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements. The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, the 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The following are notice templates provided to the member and/or provider: LA Chisholm Insufficient Information Template, LA Chisholm Member Approval Template, LA Chisholm MIOD Template, LA Chisholm NOA Template, LA NOA PDHC MMBPRV Template, LA NOA Template, LA PARTIAL DENIAL NOA Template. The following are denial notices sent to members: A223354478 NABD Denial, A223467993 NABD Denial, A223733523 NABD Denial.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide a policy that demonstrated compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that specifies compliance with the requirements of this element.		
19. The MCE may send a notice not later than the date of action if: a. The MCE has factual information confirming the death of a member; b. The MCE receives a clear written statement signed by a member that: i. The member no longer wishes services; or ii. Gives information that requires termination or reduction of services and indicates that he	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s) • 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	☐ Met ☒ Not Met ☐ NA

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understands that this must be the result of supplying that information; c. The member has been admitted to an institution where the member is ineligible under the plan for further services; d. The member's whereabouts are unknown and the post office returns agency mail directed to the member indicating no forwarding address; e. The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; f. A change in the level of medical care is prescribed by the member's physician; 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 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). 42 CFR §431.213 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §483.15(b)(4)(i-ii) 42 CFR §483.15(b)(8) 42 CFR §457.1230(d) SSA §1919(e)(7) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.2 PIHP Contract: 11.3.3.1.3	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) • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Adverse Determination Notice Policy,, page 4 • 2024 UHC UMPD • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template • A261302060 member deceased • A260776797 not eligible partial **Additional Documentation:** • UCSMM Initial Adverse Determination Notice	

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MCE Description of Process: The Initial Adverse Determination Notice Policy describes the tracking of notices of adverse determination resulting from administrative or clinical review. To ensure timeliness, verbal and other acceptable electronic means of notice are used in addition to written notices. Additionally, the Initial Adverse Determination Notice Policy page 4 indicates the Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Enrollee Grievances, Appeals and State Fair Hearings section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements. The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, the 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The following are notice templates provided to the member and/or provider: LA Chisholm Insufficient Information Template, LA Chisholm Member Approval Template, LA Chisholm MIOD Template, LA Chisholm NOA Template, LA NOA PDHC MMBPRV Template, LA NOA Template, LA PARTIAL DENIAL NOA Template. The following are denial notices sent to members: A261302060 (member deceased) and A260776797 (not eligible partial).		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy that demonstrated compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that specifies compliance with the requirements of this element.		
20. The MCE may shorten the period of advance notice to five days before the date of action if: a. The MCE has facts indicating that action should be taken because of probable fraud by the member; and	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template(s) • Tracking and reporting mechanism(s)	☐ Met ☒ Not Met ☐ NA

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b. The facts have been verified, if possible, through secondary sources. 42 CFR §431.214 42 CFR §438.210(c) 42 CFR §438.404(c)(1) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.1 PIHP Contract: 11.3.3.1.2	• Three examples of an ABD notice sent to a member due to probable fraud • HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • Initial Adverse Determination Notice Policy, , page 4 • 2024 UHC UMPD • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template **Additional Documentation:** • UCSMM Initial Adverse Determination Notice	
MCE Description of Process: The Initial Adverse Determination Notice Policy describes the tracking of notices of adverse determination resulting from administrative or clinical review. To ensure timeliness, verbal and other acceptable electronic means of notice are used in addition to written notices. Additionally, the Initial Adverse Determination Notice Policy page 4 indicates the Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Enrollee Grievances, Appeals and State Fair Hearings section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered		

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into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements. The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, the 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The following are notice templates provided to the member and/or provider: LA Chisholm Insufficient Information Template, LA Chisholm Member Approval Template, LA Chisholm MIOD Template, LA Chisholm NOA Template, LA NOA PDHC MMBPRV Template, LA NOA Template, LA PARTIAL DENIAL NOA Template.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy that demonstrated compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that specifies compliance with the requirements of this element.		
21. The MCE mails the ABD notice for denial of payment at the time of any action affecting the claim. 42 CFR §438.210(c) 42 CFR §438.404(c)(2) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.5.1.2 PIHP Contract: 11.3.3.1.4	**HSAG Required Evidence:** • Policies and procedures • Workflow/guidelines for payment denial on a claim to trigger ABD notice • UM program description • ABD notice template for denial of payment • Tracking and reporting mechanism(s) • Three case examples of the denial of payment on a claim, including date of the denial and ABD notice • HSAG will also use the data from the universe file	☐ Met ☒ Not Met ☐ NA

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	• HSAG will also use the results of the Service Authorization Denial File Review **Evidence as Submitted by the MCE:** • 2024 UHC UMPD	
MCE Description of Process: The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy that demonstrated compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that specifies compliance with the requirements of this element.		
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. 42 CFR §438.210(c-d) 42 CFR §438.404(c)(5) 42 CFR §457.1230(d) MCO Contract: 2.12.6.4.2.1 PAHP Contract: 2.5.8.3.4 PIHP Contract: 11.3.3.1.7	**HSAG Required Evidence:** • Policies and procedures • UM program description • ABD notice template for untimely determination • Service authorization log(s) within the time period under review • Tracking and reporting mechanism(s) • Three case examples of an untimely authorization decision, including the date of receipt of the authorization request and ABD notice • HSAG will also use the data from the universe file • HSAG will also use the results of the Service Authorization Denial File Review	☐ Met ☒ Not Met ☐ NA

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • Initial Adverse Determination Notice Policy, page 4 • 2024 UHC UMPD • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA PARTIAL DENIAL NOA Template • A254854686 Untimely • A245775237 Untimely • A252149889 Untimely **Additional Documentation:** • UCSMM Initial Adverse Determination Notice	
MCE Description of Process: The Initial Adverse Determination Notice Policy describes the tracking of notices of adverse determination resulting from administrative or clinical review. To ensure timeliness, verbal and other acceptable electronic means of notice are used in addition to written notices. Additionally, the Initial Adverse Determination Notice Policy page 4 indicates the Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Enrollee Grievances, Appeals and State Fair Hearings section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR §438.404, §438.10, and §438.210, the Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, the 2024 UHC UMPD SECTION F – ACCOUNTABILITY describes measurement and reporting designs that support adherence to operational, regulatory and accreditation requirements. The following are notice templates provided to the member and/or provider: LA Chisholm Insufficient Information Template, LA Chisholm Member Approval Template, LA Chisholm MIOD Template, LA Chisholm NOA Template, LA NOA PDHC MMBPRV Template, LA NOA Template, LA PARTIAL DENIAL NOA Template. The following are denial notices sent to members: A254854686 Untimely, A245775237 Untimely, A252149889 Untimely		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy that demonstrated compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that specifies compliance with the requirements of this element.		
Compensation for Utilization Management Activities		
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. 42 CFR §438.210(e) 42 CFR §438.3(i) 42 CFR §422.208 42 CFR §457.1230(d) MCO Contract: 2.12.5.1 PAHP Contract: 2.5.1.4 PIHP Contract: 6.8.5.27	**HSAG Required Evidence:** • Policies and procedures • UM program description • New hire and ongoing training for staff • Three examples of staff attestations **Evidence as Submitted by the MCE:** • Performance Assessment and Incentives Policy • 2024 UHC UMPD **Additional Documentation:** • Staff Attestations	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Performance Assessment and Incentives Policy describes the formal annual performance assessment of UM Staff. Additionally, the Performance Assessment and Incentives Policy page 3 indicates the Contractor shall ensure that compensation to		

Standard VII—Coverage and Authorization of Services		
Requirement	**Supporting Documentation**	**Score**
individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary MCO Covered Services to any Enrollee in accordance with 42 CFR §438.3{i) and 42 CFR §422.208. The 2024 UHC UMPD summarizes the philosophy, structure and standards that govern medical management, utilization management and utilization review responsibilities and functions. Additionally, SECTION F – ACCOUNTABILITY, XVIII. FINANCIAL COMPENSATION addresses UM staff decisions are not based on the quantity or types of adverse decisions rendered and do not contain incentives, direct or indirect, for any type of UM decision.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VII—Coverage and Authorization of Services							
Total	Met	=	13	X	1	=	13
	Not Met	=	8	X	0	=	0
	Not Applicable	=	2				
Total Applicable		=	21	**Total Score**		=	13

Total Score ÷ Total Applicable	=	**62%**

Standard VIII—Provider Selection

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
General Rules		
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. 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. 42 CFR §438.214(a) 42 CFR §438.214(e) 42 CFR §457.1233(a) 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	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.1, Page 7 • Additional State and Federal Credentialing Requirements, Page 27	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: The MCO credentials for all LIPs, as defined in Section 2.0, to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan as part of UnitedHealthcare's Network of Participating LIPs, including LIPs participating through a Leased Network agreement. Credentialing is required for hospital or Facility-based LIPs to whom UnitedHealthcare directs Covered Persons to receive care under a Benefit Plan or if mandated by Credentialing Authorities.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not provide evidence of compliance with the requirements. UHC did not implement written policies and procedures for the retention of network providers.		
Required Actions: The MCE must implement written policies and procedures for the retention of network providers, and those policies and procedures, at a minimum, must meet the requirements of 42 CFR §438.214.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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: a. Acute; b. Primary; c. Mental health; d. Substance use disorders. 42 CFR §438.214(b)(1-2) 42 CFR §438.214(e) 42 CFR §457.1233(a) 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	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • a- UnitedHealthcare Credentialing Plan 2023-2025, Section 4, Page 7; Section 5, Page 10 • b- UnitedHealthcare Credentialing Plan 2023-2025, Section 4, Page 7; Section 5, Page 10	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Acute, primary providers all follow the UnitedHealthcare Credentialing Plan 2023-2025.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Nondiscrimination		
3. The MCE network provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12. 42 CFR §438.214(c) 42 CFR §438.12 42 CFR §457.1233(a) MCO Contract: 2.9.9.2; 2.9.29.5 PAHP Contract: 2.6.9.11.2 PIHP Contract: 6.1.16.1	**HSAG Required Evidence:** • Policies and procedures • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 1.1, Page 1	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• NCC P-P 135 Confidentiality, Conflict of Interest and Non-discriminatory Agreements • National Credentialing Committee Meeting Minutes 9-4-2024 **Additional Documentation:** • VIII.3 NCC-P-P 135 Confidentiality, Conflict of Interest and Nondiscriminatory Agreement • VIII.3 NCC-Credentialing Committee Member Participant Confidentiality Agreement • VIII.3 NCC- UnitedHealthcare Credentialing Plan 2023-2025, Page 1 • VIII.3 NCC-P-P 118, Roles and Responsibilities of the Credentialing Committee	
MCE Description of Process: UnitedHealthcare will not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification. In our provider selection policies and procedures, we do not discriminate against particular providers that serve high-risk and special needs populations or specialize in conditions that require costly treatment. **Mechanism for monitoring for discriminatory practices:** National Credentialing Committee members are subject to all United Health Group (UHG) policies and procedures regarding confidentiality, conflict of interest, and non-discriminatory practices. The Credentialing Committee decisions documented were based on appropriate credentialing/recredentialing criteria through a peer review process in a non-discriminatory manner.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. While the documentation submitted referenced National Credentialing Committee members are subject to UHC's policies and procedures regarding non-discriminatory practices, the language did not specifically state non-discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.		
Required Actions: The MCE must revise policies and procedures, and any additional applicable documents to state that UHC does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment, consistent with 42 CFR §438.12.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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. 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. b. In all contracts with network providers, the MCE must comply with the requirements specified in 42 CFR §438.214. 42 CFR §438.12 (a)(1-2) 42 CFR §438.214 42 CFR §457.1233(a) 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	**HSAG Required Evidence:** • Policies and procedures • Provider notice template(s) for adverse credentialing and/or contracting decisions • Examples of one individual and one organizational executed provider contracts • Nondiscrimination statement for credentialing committee members • Mechanism for monitoring for discriminatory practices • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 1.1, Page 1 • NCC P&P 117, Internal Audit Process for National Credentialing • NCC P&P 118, Roles and Responsibilities of the Credentialing Committee in the Credentialing Process • NCC P-P 135 Confidentiality, Conflict of Interest and Non-discriminatory Agreements • National Credentialing Committee Meeting Minutes 9-4-2024 • Denial Letter • Organizational Provider Contract • Individual Provider Contract	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare will not discriminate with respect to participation in the Medicaid program, reimbursement, or indemnification of any provider that is acting within the scope of his/her/its license or certification under applicable State law, solely on the basis of that license or certification. In our provider selection policies and procedures, we do not discriminate against particular providers that serve high-risk and special needs populations or specialize in conditions that require costly treatment. All Credentialing Committee members are required to sign a statement attesting to DBP's nondiscrimination policy. **Mechanism for monitoring for discriminatory practices:** National Credentialing Committee members are subject to all United Health Group (UHG) policies and procedures regarding confidentiality, conflict of interest, and non-discriminatory practices. The Credentialing Committee decisions documented were based on appropriate credentialing/recredentialing criteria through a peer review process in a non-discriminatory manner.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Excluded Providers		
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. 42 CFR §438.214(d)(1) 42 CFR §457.1233(a) 42 CFR §1002.3 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	**HSAG Required Evidence:** • Policies and procedures • Three consecutive examples of documentation supporting the monthly screening of employees for sanctions/exclusions (proof of sources must be included) • Three consecutive examples of documentation supporting the monthly screening of providers for sanctions/exclusions (proof of sources must be included) • Written agreement with the delegated entity if ongoing monitoring of sanctions/exclusions will be completed by the delegated entity	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review	
	Evidence as Submitted by the MCE: • 2024 UHCCP FWA Compliance Plan-LA-CE-Policy 001 (a), Exclusions and Prohibitions section, pages 6 and 7 • Practitioner Sanctions Monitoring Policy (11-11-24), Policy Statement and Purpose section, page 1 and section Procedural Guideline for Policy Compliance section pages 2-5 • Debarment and Exclusions Monitory (5-14-24) policy, Policy Statement and Purpose section, page 1 and Procedural Guidelines for Policy Compliance, pages 2-4 • Provider Sanctions Monitoring Policy and Procedure, Overview section page 1 and 4.0 Notification and Communication section, page 6 • New Hire and Periodic Employee Sanction Review, Policy Statement and Purpose Section, page 1 and Means of Compliance section, page 2 • Full Employee Screening Oct, Nov, and December 2024, full document • Jan-Mar 2024 Provider Sanctions Report • Practitioner and Organizational Files	
MCE Description of Process: UnitedHealth Group (UHG) maintains a continuous monitoring process to identify any sanctions or exclusions involving its employees, in accordance with the New Hire Sanction Review Policy and the Periodic Sanction Review Policy. For healthcare providers, these screenings are conducted by Optum, a UHG subsidiary. Screening identify all providers whether contracted or not. The results		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
are then forwarded to the UnitedHealthcare (UHC) Clinical Team, which evaluates the findings and determines the appropriate course of action. If a provider is identified as sanctioned or excluded, the Clinical Team facilitates further analysis and dispositions of contracted providers (including Track & Trend, Terminate, Refer to National Provider Sanctions Committee (NPSC) or pends for more information. All terminations, includes Loss of License, Exclusions, NPSC Non-Loss of License Material Restrictions are sent to Network Management and UHC Benefit Ops/Advanced Triage and Intake Governance (ATIG). The Advance Triage and Intake Governance Team manage the process end to end. It sends letters to providers, terminates the provider in claims platforms, initiate member notifications and loads into our provider tracking data base. For individuals located in Louisiana, any positive sanction or exclusion matches are reported to the Health Plan Compliance Officer (HPCO). When applicable, the HPCO communicates these findings to the Louisiana Department of Health (LDH) Program Integrity Contact to ensure compliance with state-specific regulatory requirements and to facilitate proper coordination.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
State Requirements		
6. The MCE complies with any additional requirements established by the State. MCO: 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.* ii. *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.*	**HSAG Required Evidence:** • Policies and procedures • Three consecutive months of attestations submitted to LDH • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • 6a – Monthly Compliance Officer Exclusion Attestations, Oct, Nov, and Dec 2024, entire document • 6b – 2024 UHCCP FWA Compliance Plan-LA-CE-Policy 001 (a), pages 7 and 8	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
iii. *The Contractor and its Subcontractors shall conduct a search of the OIG LEIE, Louisiana Adverse Actions List Search, SAM, and other applicable sites as may be determined by LDH, monthly to capture exclusions and reinstatements that have occurred since the previous search. Any and all exclusion information discovered shall be reported to LDH within three (3) Business Days. Any individual or entity that employs or contracts with an excluded provider/individual cannot claim reimbursement from the Louisiana Medicaid Program for any items or services furnished, authorized, or prescribed by the excluded provider or individual. This is a prohibited affiliation. This prohibition applies even when the Louisiana Medicaid Program payment itself is made to another provider who is not excluded. [See 42 U.S.C. §1320a-7a(a)(6) and 42 CFR §1003.102(a)(2).]* PIHP: a. *An individual who is an affiliate, as defined in 48 CFR §2.101, of a person described in Section 13.2.2.1.* b. *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.* 42 CFR §438.214(e) 42 CFR §457.1233(a)	• 6c – 2024 UHCCP FWA Compliance Plan-LA-CE-Policy 001 (a), pages 7 and 8 – Practitioner Sanctions Monitoring Policy (11-11-24), Policy Statement and Purpose section, page 1 and section Procedural Guideline for Policy Compliance section pages 2-5 – Debarment and Exclusions Monitory (5-14-204) policy, Policy Statement and Purpose section, page 1 and Procedural Guidelines for Policy Compliance, pages 2-4 – Provider Sanctions Monitoring Policy and Procedure, page 1 and 4.0 Notification and Communication section, page 6 – New Hire and Periodic Employee Sanction Review, Policy Statement and Purpose Section, page 1 and Means of Compliance section, page 2 – LDH Notification of Exclusion -example	

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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		
MCE Description of Process: The Health Plan Compliance Officer (HPCO) submits a monthly attestation to the Louisiana Department of Health (LDH), confirming whether any exclusions were identified. This review specifically includes checks against the OIG List of Excluded Individuals/Entities (LEIE), the Louisiana Adverse Actions List, and the System for Award Management (SAM). To complete this process, the HPCO reviews the clinical sanctions list for Louisiana providers and verifies that employee screenings have been conducted. For non-UHC entities, such as the pharmacy benefit manager (PBM) and the transportation vendor, the HPCO obtains a monthly attestation confirming that their screenings were also completed. If an exclusion is identified, the HPCO must notify LDH within three business days of receiving the notification, unless LDH has already informed the health plan about the same exclusion.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Verification of Credentials		
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. a. *The MCE verifies the license directly from the state licensing or certification agency (or its website).* 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7, Intro Paragraph • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 8, Number 3 • Additional State and Federal Credentialing Requirements	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of license criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Verification of Credentials		
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. a. *This requirement does not apply to practitioners who are not qualified to write prescriptions.* 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 8, Number 4	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of DEA criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
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: a. *Board certification;* b. *Residency; or* c. *Graduation from medical or professional school.* 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7, Number 1 and 2	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: If the Applicant claims to be board certified, the MCO will Primary Source Verify board certification from the most current edition of an NCQA approved source but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If the Applicant is not board certified, then Primary Source Verification of the highest level of education listed on the Application is required.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for one practitioner's initial credentialing case file did not verify compliance with primary source verification of the highest level of education.		
Required Actions: For credentialing, the MCE must complete primary source verification for the highest of the following three levels of education and training obtained by a practitioner as appropriate prior to the credentialing decision: a. Board certification; b. Residency; or c. Graduation from medical or professional school.		
10. For credentialing and recredentialing, the MCE verifies the practitioner's board certification status, if applicable, within 180 calendar days of the credentialing decision. a. *Verification of board certification does not apply to nurse practitioners (NPS) or other health care*	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
professionals unless the MCO communicates board certification to members. 42 CFR §438.214(e) 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	**Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7, Number 2- • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7	
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of board certification for applicable providers criteria is outlined in the Credentialing and Re-credentialing Plan. Verification of mid-level providers Board Certification is used to satisfy education and training requirement only. UnitedHealthcare does not recognize Board Certification status for non-physicians practitioners.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. a. *If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date.* b. *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.* c. *If the gap in employment exceeds one year, the practitioner clarifies the gap in writing and the MCE documents its review.* 42 CFR §438.214(e)	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 8, Number 6 • UnitedHealthcare Services Inc Credentialing Accreditation Certification 2023-2026 • UnitedHealthcare_Standard VIII_Provider Selection_11_c_Narrative	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.9.30.1; 2.9.30.5 PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	**Additional Documentation:** • VIII.3 NCC- UnitedHealthcare Credentialing Plan 2023-2025, Page 8	
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of work history criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not provide evidence of compliance with the requirements. UHC's credentialing plan did not specifically state that if a gap in employment exceeds one year, the practitioner must clarify the gap in writing and UHC must document its review.		
Required Actions: For credentialing, the MCE must verify the practitioner's work history (minimum of the most recent five years of work history) within 365 calendar days of the credentialing decision. If the gap in employment exceeds one year, the practitioner must clarify the gap in writing and document its review.		
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. 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 8, Number 8 • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of history of professional liability claims criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
Practitioner Sanction Information		
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. a. *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.* 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 9, Number 10 • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of State sanctions, restrictions on licensure and limitations on scope of practice criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted for four practitioner initial credentialing case files and five practitioner recredentialing case 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.		
Required Actions: 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.		

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
14. For credentialing and recredentialing, the MCE verifies the Medicare and Medicaid sanctions within 180 days of the credentialing decision. 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 8, Number 5 • UnitedHealthcare Credentialing Plan 2023-2025, Section 4.2, Page 7	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of Medicare and Medicaid sanctions criteria is outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Credentialing Application/Attestation		
15. For credentialing and recredentialing, the MCE ensures the application and attestation, respectively include: a. *Reasons for inability to perform the essential functions of the position;* b. *Lack of present illegal drug use;* c. *History of loss of license and felony convictions;* d. *History of loss or limitation of privileges or disciplinary actions;* e. *Current malpractice insurance coverage; and*	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Practitioner Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023_2025, Section 4.2, Page 9, Number 13 and Attachment A, LIP application credentialing criteria, Number 11, Page 22,	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
f. *Current and signed attestation confirming the correctness and completeness of the application.* 42 CFR §438.214(e) 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		
MCE Description of Process: Each Provider must complete an Application with Credentialing Criteria as outlined in our Credentialing Plan with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with credentialing committee if shorter time frame. Verification of reasons for inability to perform the essential functions of the position, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary actions, current malpractice insurance coverage, and current and signed attestation confirming the correctness and completeness of the application criteria are outlined in the Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Practitioner Monitoring		
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: a. *Collecting and reviewing complaints (the MCE evaluates the history of complaints for all practitioners at least every six months);* b. *Collecting and reviewing information from identified adverse events (the MCE monitors for adverse events at least every six months); and*	**HSAG Required Evidence:** • Policies and procedures • Provider complaints tracking reports • Provider adverse events tracking reports • Credentialing committee meeting minutes • Two examples of interventions taken based on poor quality of care **Evidence as Submitted by the MCE:** • Practitioner Sanctions Monitoring Policy, Policy Statement and Purpose section, page 1, Policy	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
c. *Implementing appropriate interventions when it identifies instances of poor quality.* 2 CFR §438.214(e) 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	Provision section, 2.1.4, page 3 and National Practitioner Sanctions Committee section, page 4 • Ongoing Monitoring of Office Site Quality Policy, Page 1, Policy Statement and Purpose • QOC Investigation Improvement Action Plans and Disciplinary Action Policy, page 1, Policy Statement and Purpose • UnitedHealthcare Credentialing Plan 2023_2025, section 9, On-goig monitoring, pages 14-17 • National Credentialing Committee Meeting Minutes 9-4-2024 • 2024 Ongoing QOC Monitoring Report - SE Region (January - June) _Redacted • 2024 Ongoing QOC Monitoring Report - SE Region (July-December) _Redacted • IAP Letter	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Organizational Verification of Credentials		
17. For credentialing and recredentialing, the MCE confirms that the provider is in good standing with State and federal regulatory bodies. 42 CFR §438.214(e) MCO Contract: 2.9.30.1; 2.9.30.5	**HSAG Required Evidence:** • Policies and procedures • List of organizational provider types and corresponding licensing body in the State of Louisiana	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.6.8.1; 2.6.8.3 PIHP Contract: 6.1.12.3; 6.7.4; 6.7.6	• HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023-2025, Section 7.1, Page 12, Number 3 and Attachment C, page 24 **Additional Documentation:** • VIII.3 NCC- UnitedHealthcare Credentialing Plan 2023-2025, Page 8	
MCE Description of Process: Verification that the provider is in good standing with State and federal regulatory bodies criteria is found in our Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not verify compliance with the requirement. While UHC's credentialing plan included language that stated UHC confirms that the organizational provider is in good standing with federal regulatory bodies, the language did not include confirmation with State regulatory bodies.		
Required Actions: For credentialing and recredentialing, the MCE must confirm that the provider is in good standing with State and federal regulatory bodies.		
18. For credentialing and recredentialing, the MCE confirms that the provider has been reviewed and approved by an accrediting body. a. *If the provider is not accredited, the MCE conducts an onsite quality assessment.* i. *The MCE has a process for ensuring that the provider credentials their practitioners.* 42 CFR §438.214(e) 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	**HSAG Required Evidence:** • Policies and procedures • Onsite assessment review tool/template • HSAG will also use the results of the Organizational Credentialing and Recredentialing File Review **Evidence as Submitted by the MCE:** • UnitedHealthcare Credentialing Plan 2023_2025, page 12, Section 7.1, Number 4 page 26, and Attachment D, Facility site visits, page 26	☐ Met ☒ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	• Unaccredited Facility Site Review Tool **Additional Documentation:** • VIII.18 NCC- Unaccredited Facility Site Review Tool	
MCE Description of Process: If the Applicant is not accredited or does not hold alternative certification by an agency recognized by the Credentialing Entity, a site visit of the organization is required, and results must be found to be satisfactory as defined by the Credentialing Entity in the Credentialing Plan. In lieu of a site visit by the Credentialing Entity, a CMS or State quality review may be used if it is not more than three years old. The organization must provide evidence in the form of a final report or letter from CMS or the State, stating that it has been reviewed and passed inspection.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. The documentation submitted did not provide evidence of compliance with the requirements. UHC's onsite assessment review tool did not include an element to assess whether a provider had a process to credential its practitioners.		
Required Actions: For credentialing and recredentialing, the MCE must confirm that a provider has been reviewed and approved by an accrediting body. If the provider is not accredited, UHC must conduct an onsite quality assessment and ensure the provider has a process for credentialing its practitioners.		
Time Frames		
19. The MCE ensures that the credentialing process provides for mandatory recredentialing at a minimum of every 36 months in accordance with NCQA requirements. 42 CFR §438.214(e) MCO Contract: 2.9.30.14 PAHP Contract: 2.6.8.6 PIHP Contract: 6.7.4; 6.7.6	**HSAG Required Evidence:** • Policies and procedures • Recredentialing timeliness report during the review period • HSAG will also use the results of the Practitioner and Organizational Credentialing and Recredentialing File Review	☒ Met ☐ Not Met ☐ NA

Standard VIII—Provider Selection		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • UnitedHealthcare Credentialing Plan 2023-2025, Section 5.1, Page 10 • UnitedHealthcare Credentialing Plan 2023-2025, Section 7.2, Page 12	
MCE Description of Process: Providers will be Recredentialed at least every 36 months. Participating Provider must complete an application with criteria outlined in our Credentialing and Re-credentialing Plan.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard VIII—Provider Selection							
Total	Met	=	12	X	1	=	12
	Not Met	=	7	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	19	**Total Score**		=	12

Total Score ÷ Total Applicable	=	**63%**

Standard IX—Subcontractual Relationships and Delegation

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
General Rule		
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. 42 CFR §438.230(b)(1) 42 CFR §457.1233(b) 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	**HSAG Required Evidence:** • Policies and procedures **Evidence as Submitted by the MCE:** • UHCLA Medical Intersegment Agreement Template, section 3.3, page 3 • Delegated Entity Oversight, D. Subcontractor Agreements section, page 2 **Additional Documentation:** • IX. 1-3, 6 Delegated Entity Oversight Policy	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used. Any provision in the regulatory appendix will supersede the contractual provision. The contract between UHC and Magellan/Prime Therapeutics is an LDH developed contract template applicable to all MCOs and was to be implemented without changes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Contract or Written Arrangement		
2. Each contract or written arrangement with a delegate must specify: a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement. b. The delegate agrees to perform the delegated activities and reporting responsibilities specified in compliance with the MCE's contract obligations. 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. *42* CFR §438.230(b)(2) 42 CFR §438.230(c)(1) 42 CFR §457.1233(b) 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	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • 2.a. – UHCLA Medical Intersegment Agreement Template, Exhibit B in its entirety, page 21 – United-Magellan_Pharmacy Benefit Management Services Agreement, pages 3, 21, 29, 30, 100, and 118-124 – Delegated Entity Oversight, D. Subcontractor Agreements section, page 2 • 2.b. – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024 Section 3.11 pages 4-5 and Section 4.7 pages 13 and 14 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 3.11 pages 4-5 and Section 4.7 page 14 – United-Magellan_Pharmacy Benefit Management Services Agreement, pages 21 and 117 – Delegated Entity Oversight, D. Subcontractor Agreements section, page 2	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	• 2.c. – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 5.5 pages 21-22 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 5.5 page 22 – Delegated Entity Oversight, D. Subcontractor Agreements section, page 2 **Additional Documentation:** • IX. 1-3, 6 Delegated Entity Oversight Policy	
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. Any provision in the regulatory appendix will supersede the contractual provision. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used. Each subcontractor is assigned a Vendor Relationship Owner who is responsible for developing processes to ensure contractual requirements are met. Processes can vary by subcontractor depending on the delegated activities and operations of the subcontractor. The contract between UHC and Magellan/Prime Therapeutics is an LDH developed contract template applicable to all MCOs and was to be implemented without changes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The contract or written arrangement indicates that the delegate agrees to comply with all applicable Medicaid laws, regulations, including applicable subregulatory guidance and contract provisions and MCO: a. *rules, policies, procedures, manuals, the State Plan, and Waivers.*	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:**	☐ Met ☒ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.230(c)(2) 42 CFR §457.1233(b) MCO Contract: 2.2.3.4.4 PAHP Contract: 2.15.6.3 PIHP Contract: 1.5.3.1	• LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Sections 4.7 and 4.8 pages 13-14 • LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Sections 4.7 and 4.8 page 14 • Delegated Entity Oversight, D. Subcontractor Agreements section, page 2 • United-Magellan_Pharmacy Benefit Management Services Agreement, pages 11 and 12 **Additional Documentation:** • Narrative • IX. 1-3, 6 Delegated Entity Oversight Policy	
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. Any provision in the regulatory appendix will supersede the contractual provision. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's submissions did not comport with the required federal and State language of this requirement, which is exacting.		
Required Actions: 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.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
4. The contract or written arrangement indicates, and the delegate agrees that: 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. 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. 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. 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. 42 CFR §438.230(c)(3) 42 CFR §457.1233(b) 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	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • 4.a – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 4.5 (a) and 4.5 (d) pages 11-12 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 4.5 (a) and 4.5 (d) pages 11-12 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 11 • 4.b – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 4.5 (a) and 4.5 (d) pages 11-12 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 4.5 (a) and 4.5 (d) pages 11-12 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 11 • 4.c – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 4.5 (a) and 4.5 (d) pages 11-12	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	– LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 4.5 (a) and 4.5 (d) pages 11-12 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 11 • 4.d – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 4.5 (a) and 4.5 (d) pages 11-12 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 4.5 (d) 12 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 11 **Additional Documentation:** • IX. 4 Narrative Modivcare Amendment 11-Regulatory Appendix Update • IX.4 UHC LA_Amendment 11 to Addendum 42_07.01.2023 4.a-d-section 4.5 (a) and (d), page 13 and page 14	
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. Any provision in the regulatory appendix will supersede the contractual provision. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used. Each subcontractor is assigned a Vendor Relationship Owner who is responsible for developing processes to ensure contractual requirements are met. Processes can vary by subcontractor depending on the delegated activities and operations of the subcontractor. Request for delegate records for any audits conducted by agencies responsible for healthcare oversight, e.g., The State, Centers for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees, are facilitated by the MCE.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The contract or written arrangement: MCO: a. *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.* 42 CFR §438.230 42 CFR §457.1233(b) MCO Contract: 2.2.3.4.5 PAHP Contract: NA PIHP Contract: NA	**HSAG Required Evidence:** • Delegation agreement/contract template • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • 5.a – UHCLA Medical Intersegment Agreement Template, section 11.4, page 14 – LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 4.8 page 14 and Section 4.28 page 19 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 4.8 page 14 and Section 4.28 page 19 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 13	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. Any provision in the regulatory appendix will supersede the contractual provision. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
Monitoring and Auditing		
6. Monitoring subcontractor's performance shall be monitored: MCO: a. *On an ongoing basis and perform a formal review annually. At a minimum, the annual review shall include any performance concerns identified by LDH.* PAHP: a. *On an ongoing basis and subject it to formal review according to a periodic schedule consistent with industry standards.* PIHP: a. *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.* 42 CFR §438.230 42 CFR §457.1233(b) MCO Contract: 2.2.3.6 PAHP Contract: 2.15.6.4 PIHP Contract: 1.5.3	**HSAG Required Evidence:** • Delegation agreement/contract template • Monitoring and audit documentation • Annual formal review • HSAG will also use the results from the Delegation File Review **Evidence as Submitted by the MCE:** • 6 MCO: a – UHC Business LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024, Section 6.2, page 22 – LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24, Section 6.2, page 22 – United-Magellan_Pharmacy Benefit Management Services Agreement, page 110 – Delegated Entity Oversight, page 2; Section Vendor Relationship Owner Process section, page 4; Specific Tasks for Each Vendor or Delegated Entity section, pages 4 and 5; and Policy section, page 6 – UHC Business Contracts and Delegations policy, Statement and Purpose sections, page 1; Delegation Oversight section, page 2 – Samples 1-4 contain monitoring, auditing and annual review information	☒ Met ☐ Not Met ☐ NA

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • IX. 1-3, 6 Delegated Entity Oversight Policy	
MCE Description of Process: UHC uses multiproduct line contacting templates as part of its contracting process. However, contracts contain a state specific line of business regulatory appendix to ensure state requirements are incorporated into the contract. Any provision in the regulatory appendix will supersede the contractual provision. The regulatory appendix is a fluid document and can change depending on the LDH review process. During the review period, there are 2 versions of the regulatory appendix being used. Each subcontractor is assigned a Vendor Relationship Owner who is responsible for developing processes to ensure contractual requirements are met. Processes can vary by subcontractor depending on the delegated activities and operations of the subcontractor. Monitoring of the state's single PBM also consists of weekly calls hosted by the PBM and attended by all MCOs and LDH. Issues are discussed and addressed collectively with LDH input.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	5	X	1	=	5
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	5

Total Score ÷ Total Applicable	=	**83%**

Standard X—Practice Guidelines

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
Adoption of Practice Guidelines		
1. The MCE adopts practice guidelines that are based on valid and reliable clinical evidence or a consensus of providers in the particular field. 42 CFR §438.236(b)(1) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.1 PAHP Contract: 2.5.5.1.1 PIHP Contract: 7.4.5.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • National Case Mgt Clinical Practice Guideline Policy: entire document • UHC LA Case Mgt Policy Rider - Clinical Practice Guidelines: entire document • Optum Clinical Criteria Change Summary: pgs. 2-4 highlighted • Medical Technology Assessment Committee Minutes 040424: pg. 1	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The MCE process involves several key steps to ensure that clinical guidelines are based on valid and reliable evidence or a consensus among providers. Here's a general description of the process: 1. **Identification of Clinical Areas**: Determine which clinical areas or conditions need evaluation based on factors including utilization patterns such as high volume of member diagnoses, high risk, and/or regulatory requirements. 2. **Guideline Review and Evidence Gathering**: Conduct a thorough review of current medical literature and gather clinical evidence. This includes studies, clinical trials, and expert opinions from state approved and nationally recognized organizations (e.g., American Psychiatric Association (APA), Substance Abuse and Mental Health Services Administration (SAMHSA)). 3. **Development of Guidelines**: Based on the gathered evidence, choose the practice guidelines that align with needs and requirements. These guidelines should be clear, actionable, and based on the best available evidence.		

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
4. **Consensus Building**: Engage with healthcare providers to build a consensus on the guidelines. This may involve discussions, meetings, and revisions to ensure the guidelines are practical and acceptable. 5. **Implementation**: Introduce the guidelines into clinical practice. This may involve training, dissemination of materials, and integration into clinical workflows.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. The MCE adopts practice guidelines that consider the needs of the MCE's members and: MCO: a. adopts clinical practice guidelines for at least the conditions listed below: i. Schizophrenia; ii. Attention Deficit Hyperactivity Disorder (ADHD); iii. Autism Spectrum Disorder; iv. Depression; v. Generalized Anxiety Disorder; vi. Post-Traumatic Stress Disorder; vii. Suicidal Behavior; viii. Oppositional Defiant Disorder; ix. Bipolar Disorder; and x. Substance Use Disorders. PIHP: a. develops clinical practice guidelines for: i. ADHD ii. Trauma Informed Care	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval **Evidence as Submitted by the MCE:** • National Case Mgt Clinical Practice Guideline Policy: entire document • UHC LA Case Mgt Policy Rider - Clinical Practice Guidelines: entire document • Optum Clinical Criteria Change Summary: pages 2-4 • Medical Technology Assessment Committee Minutes 040424: pg. 1	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
iii. Depression and Conduct Disorder 42 CFR §438.236(b)(2) 42 CFR §457.1233(c) 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		
MCE Description of Process: UHC adopts practice guidelines that consider the needs of the members by determining which clinical areas or conditions could benefit from standardized evidence-based practices. Utilization patterns such as high volume of member diagnoses, or short- or long-term high risk to the member, are taken into consideration. Regulatory requirements for certain CPGs are also factored in.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The MCE adopts practice guidelines that are adopted in consultation with network providers. 42 CFR §438.236(b)(3) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.3 PAHP Contract: 2.5.5.1.3 PIHP Contract: 7.4.5.1	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines • MCE-specific meeting minutes documenting committee review and approval • Evidence of consultation of network providers **Evidence as Submitted by the MCE:** • National Case Mgt Clinical Practice Guideline Policy: entire document • UHC LA Case Mgt Policy Rider - Clinical Practice Guidelines: entire document • Optum Clinical Criteria Change Summary: pgs. 2-4 for adopted practices; pg. 1 and 2 for evidence of specific meeting minutes and approval; pg. 1, 1st bullet for consultation of providers	☐ Met ☒ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: An annual review and solicitation of input of Optum Clinical Criteria was conducted. Solicitation includes input from providers in all U.S. states, Optum Staff and the Clinical and Scientific Advisory Council (CSAC) external experts. There were no recommended supportive tools or processes to consider at the time of the January 16th Optum CQOC meeting in 2024. Provider input is also solicited from network providers who are members of the organizations that create the guidelines to begin with. Additional opportunities for network provider input would include the exit conferences during the Medical Record Reviews (MRRs), and new provider orientations as these are where guidelines would be a focus point.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC staff members described a process to adopt practice guidelines that are adopted in consultation with network providers through the Provider Advisory Committee (PAC). Furthermore, UHC confirmed that during 2024 (review period), practice guidelines were not included in the PAC agenda.		
Required Actions: The MCE must implement a process to adopt practice guidelines that are adopted in consultation with network providers through its established process, the PAC.		
4. The MCE adopts practice guidelines that are: MCO/PAHP: a. reviewed and updated periodically as appropriate. PIHP: a. Reviewed annually and updated periodically as appropriate. b. Approved by LDH within twelve (12) months of contract execution, upon revision, and upon adoption of new clinical practice guidelines. 42 CFR §438.236(b)(4) 42 CFR §457.1233(c) MCO Contract: 2.12.12.4.4 PAHP Contract: 2.5.5.1.4 PIHP Contract:7.4.5.4; 7.4.7.2	**HSAG Required Evidence:** • Policies and procedures • List of adopted practice guidelines; including the last reviewed/revised date for each practice guideline • MCE-specific meeting minutes documenting committee review and approval, and/or planned meeting schedule and agenda **Evidence as Submitted by the MCE:** • National Case Mgt Clinical Practice Guideline Policy: entire document • UHC LA Case Mgt Policy Rider - Clinical Practice Guidelines: pgs. 1,2 • Optum Clinical Criteria Change Summary: pgs. 2-4 for adopted practices; pg. 1 and 2 for evidence of specific meeting minutes	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• Provider Express Clinical Practice Guideline Landing Page	
MCE Description of Process: UHC follows the Code of Federal Regulations 438.236 regarding CPGs which notes the guidelines have to be valid, based on enrollee needs, adopted with network provider input, and are reviewed periodically as appropriate. Guidelines are reviewed annually, but are updated as needed, such as when nationally recognized organizations, such as the American Academy of Pediatrics (AAP) deems the current guideline in need of revision. For example, the AAP did not update their ADHD guideline from 2011, until 2019. If the opposite occurred, such as a nationally recognized clinical practice guideline was updated in the middle of the year, UHC would present the guideline for review and approval by the appropriate quality committees. Once approved, the CPG would be updated and disseminated among internal and external customers.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Dissemination of Guidelines		
5. The MCE disseminates the guidelines to: a. All affected providers b. Members and potential members, upon request 42 CFR §438.236(c) 42 CFR §457.1233(c) MCO Contract: 2.12.12.5 PAHP Contract: 2.5.5.3 PIHP Contract: 7.4.7	**HSAG Required Evidence:** • Policies and procedures • Evidence of dissemination to providers (i.e., provider newsletter, provider manual, provider website) • Evidence of dissemination to members (i.e., member newsletter, member handbook, member website) **Evidence as Submitted by the MCE:** • National Case Mgt Clinical Practice Guideline Policy: entire document • UHC LA Behavioral Health Provider Dev & Mgt Plan: pgs. 31, 45, 46 (5a)	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• 2024 Care Provider Manual LA: pgs. 19, 77, 86 highlighted (5a) • LA-Medicaid-Newsletter-Spring-2024-EN: pg. 1 (5b) • Live and Work Well Website Screenshot: (5b)	
MCE Description of Process: Guidelines are disseminated through all channels of communications such as but not limited to: the UHC website, the Provider Express and Live and Work Well website, the provider portal, provider and member newsletters, new member letters, and in the course of provider and member education.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Application of Guidelines		
6. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. 42 CFR §438.236(d) 42 CFR §457.1233(c) MCO Contract: 2.12.12.6 PAHP Contract: 2.5.5.4 PIHP Contract: None	**HSAG Required Evidence:** • Policies and procedures • Coverage guidelines/criteria • Member educational guidance (i.e., disease management) • Member materials (i.e., member handbook, member newsletters) • Three examples of coverage denial notices **Evidence as Submitted by the MCE:** • UHC LA Case Mgt Policy Rider - Clinical Practice Guidelines: pgs. 1, 2 • LA-Medicaid-Newsletter-Spring-2024-EN, pg. 1 • Live and Work Well Website: (educational guidance)	☒ Met ☐ Not Met ☐ NA

Standard X—Practice Guidelines		
Requirement	**Supporting Documentation**	**Score**
	• Denial Letter Sample One: entire document • Denial Letter Sample Two: entire document • Denial Letter Sample Three: entire document • LA Clinical Practice Guideline Record Tool: entire document • UHC LA Integrated New Member EN: pgs. 1,2,3,4,5,7 highlighted (member education)	
MCE Description of Process: Practice Guidelines are taken into consideration when determining benefits, approval or denial of certain practices/procedures. Guidelines are also incorporated into suggested best practices for specific member needs, particularly in the behavioral health arena.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard X—Practice Guidelines							
Total	Met	=	5	X	1	=	5
	Not Met	=	1	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	6	**Total Score**		=	5

Total Score ÷ Total Applicable	=	**83%**

Standard XI—Health Information Systems

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
General Rule		
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: a. Utilization; b. Claims; c. Grievances and appeals; and d. Disenrollments for other than loss of Medicaid eligibility. 42 CFR §438.242(a) 42 CFR §457.1233(d) MCO Contract: 2.19.1.2 PAHP Contract: 2.13.1.2 PIHP Contract: 14.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • Systems integration mapping documentation • Most current completed Information Systems Capabilities Assessment Tool (ISCAT) through recent EQR activities (i.e., performance measure validation [PMV]) • Technical manual(s) • List of disenrollment codes (i.e., reasons for disenrollment) provided by the State • Screenshot of disenrollment codes available in the disenrollment system • HSAG will use the results from the information systems demonstration, including reporting capabilities • HSAG will use the results from the systems demonstrations **Evidence as Submitted by the MCE:** • General Rule • Disenrollment Codes Narrative; all pages • Logical Architecture • Marketecture	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • Att 2_2024 LA_NAV_ISCAT_F1_.docx • UnitedHealth Group - Data Management - Data Storage, Encryption and Backups Overview.pdf • UnitedHealth Group - Policies - Information Security - 12A Business Continuity and Disaster Recovery.pdf • UnitedHealth Group - Policies - Information Security - 12B Backup and Recovery.pdf	
MCE Description of Process: UnitedHealthcare Community Plan of Louisiana maintains a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of Medicaid managed care requirements. Refer to additional submitted evidence for details: Disenrollment reasons are tracked using codes from the 834 enrollment file, which are cross-walked to internal codes and stored in the member record in CSP Facets. The Disenrollment Codes Narrative includes a mapping of eligibility reason codes to internal system codes.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Compliance was assessed based on UHC's documentation submitted and also through conversations during the interview session. **Recommendations:** HSAG recommends that the MCE develop policies and procedures that apply the requirements of the federal regulations and State contract requirements regarding the health information system processes for the collection, analysis, integration, and reporting of data to achieve the objectives of the Medicaid managed care requirements.		
Required Actions: No action required.		
Basic Elements of a Health Information System		
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. 42 CFR §438.242(b)(2)	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines • Encounter data collection and submission guidelines	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §457.1233(d) MCO Contract: 2.18.1.1.5 PAHP Contract: 2.13.1.7.4 PIHP Contract: 16.1.1	• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Basic Elements • Flow Diagram **Additional Documentation:** • https://www.ldh.la.gov/medicaid/mce-system-companion-guide • https://www.uhc.com/privacy • XI-Q2_UHC Life of an Encounter Process Flow • XI.2.3.4.5_Claims Flow Diagram	
MCE Description of Process: UnitedHealthcare Community Plan of Louisiana collects data on member and provider characteristics as specified by LDH and on all services furnished to members through an encounter data system or other method.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Compliance was assessed based on UHC's documentation submitted and also through conversations during the interview session. **Recommendations:** HSAG recommends that the MCE develop policies and procedures for its encounter data system. These documents should outline how the MCE collects all member and provider characteristic data, and all services furnished to members, to meet both federal regulations and State contract requirements.		
Required Actions: No action required.		
3. The MCE ensures that data received from providers is accurate and complete by:	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims submission requirements document • Claims data collection and processing guidelines	☐ Met ☒ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments. b. Screening the data for completeness, logic, and consistency. 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. 42 CFR §438.242(b)(3) 42 CFR §457.1233(d) MCO Contract: 2.18.15.3.1; 2.18.15.10 PAHP Contract: 2.14.11.3 PIHP Contract: 16.6.2	• Claim validation processes • Claim timeliness reports • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Flow Diagram • UHC 221 Claim Payment Summary Reports 2024 **Additional Documentation:** • XI.3_EDI-HIPAA-Claim_Edits • XI.3_EDI-837P-CG-005010X222A1.Health Care Claim – Professional Companion Guide • XI.3_EDI-837i-CG-005010X223A2_Health Care Claim – Institutional Companion Guide	
MCE Description of Process: Electronic claim data is screened for completeness, logic and consistency via HIPAA Validation Edits as evidenced in the HIPAA_Validation_Edits documents. UnitedHealthcare Community Plan of Louisiana ensures that data received from providers is accurate and complete.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide sufficient evidence of compliance with federal and State regulations that mandate a process for ensuring provider-submitted data are accurate and complete. This includes verifying the timeliness of reported data, screening for completeness, and collecting data in standardized formats.		
Required Actions: The MCE must develop a process, and maintain within its documentation, that the MCE ensures that data received from providers is accurate and complete by: a. Verifying the accuracy and timeliness of reported data, including data from network providers the MCE is compensating on the basis of capitation payments.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
b. Screening the data for completeness, logic, and consistency. 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.		
4. The MCE makes all collected data available to the State and upon request to CMS. 42 CFR § 438.242(b)(4) 42 CFR §457.1233(d) MCO Contract: 2.18.18.1.1 PAHP Contract: 2.13.9.1.2 PIHP Contract: 14.9.1.1	**HSAG Required Evidence:** • Policies, procedures, and workflows • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Flow Diagram.pdf • Basic Elements.docx • Electronic Communications Gateway (ECG	☒ Met ☐ Not Met ☐ NA
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Compliance was assessed based on UHC's documentation submitted and also through conversations during the interview session. **Recommendations:** HSAG recommends that the MCE develop policies and procedures for making all collected data available to the State and upon request to CMS to meet both federal and State contract requirements.		
Required Actions: No action required.		
Claims Processing		
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	**HSAG Required Evidence:** • Policies, procedures, and workflows • Claims data collection and processing guidelines	☐ Met ☒ Not Met

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
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). 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) MCO Contract: 2.18.1.1 PAHP Contract: 2.14.2.1.3; 2.14.2.1.4 PIHP Contract: 15.2.2.7	• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • Claim Processing • Logical Architecture **Additional Documentation:** • XI.3_EDI-HIPAA-Claim_Edits • XI.3_EDI-837P-CG-005010X222A1.Health Care Claim – Professional Companion Guide • XI.3_EDI-837i-CG-005010X223A2_Health Care Claim – Institutional Companion Guide	☐ NA
MCE Description of Process: UnitedHealthcare Community Plan of Louisiana 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 LDH.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not provide sufficient evidence of a process that complies with Section 6504(a) of the Affordable Care Act. This includes ensuring its claims and retrieval systems can collect the necessary data elements for the State's claims processing systems to meet the requirements of Section 1903(r)(1)(F) of the Affordable Care Act.		
Required Actions: The MCE must develop a process, and maintain within its documentation, that 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 Affordable Care Act (electronic claims submission).		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Application Programming Interface		
6. The MCE implements an Application Programming Interface (API) as specified in 42 CFR §431.60 (member access to and exchange of data) as if such requirements applied directly to the MCE. Information is made accessible to its current members or the members' personal representatives through the API as follows: 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; b. Encounter data no later than one business day after receiving the data from providers compensated on the basis of capitation payments; c. All other encounter data, including adjudicated claims and encounter data from any subcontractors. d. Clinical data, including laboratory results, no later than one business day after the data is received by the MCE; 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. 42 CFR §438.242(b)(5) 42 CFR §431.60 42 CFR §457.1233(d) 45 CFR §170.213	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plan/results member educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the API demonstration **Evidence as Submitted by the MCE:** • API • Registered_3rd_Party_Apps.xlsx	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: None PAHP Contract: None PIHP Contract: None		
MCE Description of Process: UnitedHealthcare Community Plan of Louisiana implements and maintains 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 MCO. Information is made accessible to its current members or the members' personal representatives through an API.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** HSAG recommends that UHC prioritize continued Application Programming Interface (API) development as it is essential not only enabling valuable business functions but also meeting federal regulatory requirements.		
Required Actions: No action required.		
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. 42 CFR §438.242(b)(6) 42 CFR §431.70 42 CFR §438.10(h)(1-2) 42 CFR §457.1233(d) 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	**HSAG Required Evidence:** • Policies, procedures, and workflows • API documentation such as project plan(s), testing plans/results, stakeholder educational materials, website materials, etc. • List of registered third-party applications • HSAG will use the results from the web-based provider directory demonstration **Evidence as Submitted by the MCE:** • API • Registered_3rd_Party_Apps	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. **Recommendations:** 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).		
Required Actions: No action required.		
Member Encounter Data		
8. The MCE collects and maintains sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. 42 CFR §438.242(c)(1) 42 CFR §457.1233(d) 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	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data collection requirements • 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) • HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • XI-Q8-9_UHC LA Encounter P & P • XI-Q8-9_UHC Life of an Encounter Process Flow • XI-Q8-9_UHC LA Encounter 837 samples **Additional Documentation:** • XI-Q8_UHC Provider flow Facets to NEMIS to submission	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
	• XI-Q8-9_UHC Encounter 837 Billing_Rendering_Attending per MCO System Companion Guide • XI-Q8-9_UHC LA Encounter P & P – Page 3 in section IV.B.1.v • XI-Q8_UHC Provider flow Facets to NEMIS to submission	
MCE Description of Process: UnitedHealthcare retains all required data elements (e.g., procedures, diagnoses, place of service, units of service, billed amounts, allowed amounts, paid amounts and all providers' information *(Billing, Rendering, etc.)* as well as other detailed claims data) in our Community and State's Strategic Platform (CSP) Facets. Weekly extracts from CSP Facets & Vendor files are loaded into our National Encounter Management Information System (NEMIS). NEMIS creates encounter files (*formats below*) for weekly submissions to LDH via Gainwell utilizing their system companion guide. *(837P (professional claims), 837I (institutional claims), and NCPDP (pharmacy) file formats for electronic transactions.)*		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Compliance was assessed based on UHC's documentation submitted and also through conversations during the interview session. **Recommendations:** HSAG recommends that the MCE develop policies and procedures for collecting and maintaining sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members, to meet both federal and State contract requirements.		
Required Actions: No action required.		
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. 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.	**HSAG Required Evidence:** • Policies, procedures, and workflows • Encounter data submission requirements • Three concurrent months/quarters of submission compliance (acceptance/rejection reports) • Two samples/screenshots of encounter data with allowed amount and paid amount fields (one sample must include encounter data from a sub-capitated source)	☒ Met ☐ Not Met ☐ NA

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
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. MCO: a. *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* PAHP: a. *Submit complete and accurate encounter data at least monthly.* PIHP: a. *Submit complete and accurate encounter data at least weekly* 42 CFR §438.242(c)(2-4) 42 CFR §438.818 42 CFR §457.1233(d) 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	• HSAG will use the completed ISCAT and results from the information systems demonstration, including reporting capabilities **Evidence as Submitted by the MCE:** • XI-Q8-9_UHC LA Encounter P & P • XI-Q8-9_UHC Life of an Encounter Process Flow • XI-Q9_UHC_LA Encounter 2024 report • XI-Q8-9_UHC LA Encounter 837 samples **Additional Documentation:** • XI-Q8_UHC Provider flow Facets to NEMIS to submission • XI-Q8-9_UHC LA Encounter P & P – Page 3 in section IV.B.1.v • XI-Q8-9_UHC Encounter Data	
MCE Description of Process: UnitedHealthcare retains all required data elements (e.g., procedures, diagnoses, place of service, units of service, billed amounts, allowed amounts, paid amounts and all providers' information *(Billing, Rendering, etc.)* as well as other detailed claims data) in our Community and State's Strategic Platform (CSP) Facets. Weekly extracts from CSP Facets & Vendor files are loaded into our National Encounter Management Information System (NEMIS). NEMIS creates encounter files (*formats below*) for weekly submissions to LDH via Gainwell utilizing their system companion guide. *(837P (professional claims), 837I (institutional claims), and NCPDP (pharmacy) file formats for electronic transactions.)*		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element. Compliance was assessed based on UHC's documentation submitted and also through conversations during the interview session.		

Standard XI—Health Information Systems		
Requirement	**Supporting Documentation**	**Score**
Recommendations: HSAG recommends that UHC develop policies and procedures to ensure its encounter data system collects and submits complete and accurate information at least monthly to LDH, but also includes identifying the provider for each service and providing both allowed and paid amounts, which is necessary for meeting State and federal reporting requirements.		
Required Actions: No action required.		

Results for Standard XI—Health Information Systems							
Total	Met	=	7	X	1	=	7
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	9	**Total Score**		=	7

Total Score ÷ Total Applicable	=	**78%**

Standard XII—Quality Assessment and Performance Improvement

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
General Rules		
1. The MCE establishes and implements an ongoing comprehensive quality assessment and performance improvement (QAPI) program for the services it furnishes to its members. 42 CFR §438.330(a)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.2.1 PAHP Contract: 2.11.1.1.1 PIHP Contract: 12.1.1	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan **Evidence as Submitted by the MCE:** • Quality Management Policy • Quality Management Policy Attachment UCSMM.05.10 Quality Management Program • QAPI Program Description 2024 • QAPI program work plan	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: United Healthcare (UHC) conducts a comprehensive Quality Improvement (QI) Program annually to ensure the highest standards of care and service. The process involves several key steps: 1. **Program Description**: Each year, UHC outlines the objectives, scope, and methodologies of the QI Program. This includes defining the metrics and benchmarks for quality and performance. 2. **Evaluation**: The program undergoes a thorough evaluation to assess its effectiveness. This involves analyzing data from various sources, including patient outcomes, service utilization, and feedback from stakeholders. 3. **Work Plan Development**: Based on the evaluation, a detailed work plan is developed. This plan addresses identified areas of need and sets forth specific actions and initiatives to drive improvement. 4. **Revisions and Updates**: The program description, evaluation findings, and work plan are reviewed and revised annually to reflect new insights and emerging priorities. 5. **Committee Presentations**: The updated program details are presented at various committee meetings both locally and nationally. These presentations ensure transparency, gather additional feedback, and facilitate collaborative efforts to enhance quality.		

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Requirement	**Supporting Documentation**	**Score**
This cyclical process ensures that UHC's Quality Improvement Program remains dynamic, responsive, and aligned with the goal of delivering exceptional healthcare services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Basic Elements of QAPI Programs		
2. The QAPI program includes mechanisms to assess both underutilization and overutilization of services. 42 CFR §438.330(b)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.3 PAHP Contract: 2.11.1.1.3 PIHP Contract: 12.1.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Evidence demonstrating assessment of underutilization of services (e.g., committee meeting minutes, reports) • Evidence demonstrating assessment of overutilization of services (e.g., committee meeting minutes, reports) **Evidence as Submitted by the MCE:** • Policy - Mechanisms for over-utilization and under-utilization • Policy – Mechanisms to Detect Over and Under Utilization Attachment A • Policy – Mechanisms to Detect Over and Under Utilization Attachment B • Procedure - Mechanisms To Detect Over Under Utilization	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• QAPI Program Description 2024 • QAPI program work plan • QAPI Program Evaluation 2024 • Evidence of mechanisms to assess both underutilization and overutilization of services • Population Health Management Annual Attachment • 2024 PHM Annual Plan • NQOC Agenda and Meeting Minutes 02-07-24 • 2024 NET 1-3 Report Final NQOC approved • QAPI Agenda and Meeting Minutes 2024 Q2 **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	

MCE Description of Process: The UHC Quality Optimization and Insights (QOI) Team generates the Utilization Dashboard on an annual basis, with measures that may include, but not limited to, the measures outlined in:

a. **Attachment A - Table of Measures: Utilization of Healthcare Services**. In addition to the list of measures, the data table includes benchmarks for over- and under- utilization, with less than the 5th percentile representing possible under-utilization and greater than 95th percentile representing possible over-utilization, unless otherwise indicated.

b. **Attachment B - Table of Measures: Utilization of Healthcare Services for Members with Special Health Care Needs**. In addition to the list of measures, the data table includes benchmarks for under-utilization with less than the 25th percentile representing possible under-utilization, unless otherwise indicated.

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.330(b)(4) 42 CFR §457.1240(b) MCO Contract: 2.16.2.3.8 PAHP Contract: 2.11.1.1.4 PIHP Contract: 12.1.1.3	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Definition of members with special health care needs • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess special health care needs **Evidence as Submitted by the MCE:** • Policy - Mechanisms for over-utilization and under-utilization • Policy – Mechanisms to Detect Over and Under Utilization Attachment A • Policy – Mechanisms to Detect Over and Under Utilization Attachment B • Procedure - Mechanisms To Detect Over Under Utilization • QAPI Program Description 2024 • QAPI program work plan	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• QAPI Program Evaluation 2024 • Evidence of Definition - Mechanisms for over-utilization and under-utilization • Assessment Tools_ LA Core Model_Evidence_2024 • Assessment_Tools_ Pediatric core 3.0 **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation • XII.3 Policy-Evidence of SHCN member definition • XII.3 Evidence of mechanisms to assess members with SHCN • XII.3 Evidence of SOP_C&S_Mechanisms_To Detect_Over_Under_Utilization_2024_SHCN	
MCE Description of Process: UnitedHealthcare C&S recognizes the unnecessary risk that over-utilization and under-utilization of healthcare services may present to members. UHC is committed to demonstrating that it has systems and processes in place to monitor and evaluate use of healthcare services. Louisiana C&S health plan may review health plan level utilization data to inform decisions and compare to benchmarks. If applicable, the health plan may evaluate utilization metrics for specific HEDIS measures at a health plan and/or a practitioner level. Rates are reported in a Utilization Dashboard as published in the NCQA Quality Compass. At a practitioner level, rates are compared to the health plan rate. If the data falls outside of the desired ranges, it may be analyzed for further investigation. The utilization finding may be communicated to practitioners and/or health plan committees.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
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: a. Assessment of care between care settings; and b. Comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable. 42 CFR §438.330(b)(5)(i) 42 CFR §457.1240(b) MCO Contract: NA PAHP Contract: None PIHP Contract: NA	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Assessment tools • Clinical guidance/criteria • Metrics/performance measures to assess LTSS • Medical record audit tools and results **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: UnitedHealthcare Louisiana C&S Plan does not have LTSS		
HSAG Findings: Long-term services and supports (LTSS) is not part of the contract; therefore, HSAG has determined that this requirement is not applicable.		
Required Actions: No action required.		
Performance Measurement		
5. The QAPI program includes the collection and submission of performance measurement data. The MCE annually: a. Measures and reports to the State on its performance, using the standard measures required by the State; 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	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Performance measures reports	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
c. Performs a combination of the activities described in subelements (a) and (b). 42 CFR §438.330(b)(2) 42 CFR §438.330(c) 42 CFR §457.1240(b) 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	• Evidence of submission of performance measurement reports to the State **Evidence as Submitted by the MCE:** • Policy - HEDIS Data Auditing • QAPI Program Description 2024 • QAPI program work plan • QAPI Program Evaluation 2024 • Performance Measures Report Final 2024 rates • Evidence of submission of performance measurement reports to the State **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	

MCE Description of Process: All appropriate data feeds are received timely from medical claims and encounters, member enrollment, provider files, pharmacy, behavioral health, and important internal/external databases.

All data within the HEDIS® data repositories are required to pass the rigors and audit standards of the official NCQA HEDIS® Audit Guidelines for the most current year, which govern the audit practices of NCQA auditors.

HEDIS® software used for preparation of HEDIS® reports is NCQA certified. Errors found in the software are promptly reported to the software vendor and monitored for correction.

Reports prepared through HEDIS® or other vendor software using the HEDIS® data are quality checked for accuracy prior to distribution.

HSAG Findings: HSAG has determined that the MCE met the requirements for this element.

Required Actions: No action required.

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Requirement	**Supporting Documentation**	**Score**
Performance Improvement Projects		
6. The QAPI program includes performance improvement projects (PIPs). a. The MCE conducts PIPs that focus on both clinical and non-clinical areas. MCO: a. *The MCO shall perform at least three (3) LDH-approved PIPs of which at least one must be a behavioral health PIP.* PIHP: a. *The PIHP shall perform a minimum of one LDH approved PIP.* 42 CFR §438.330(b)(1) 42 CFR §438.330(d)(1) 42 CFR §457.1240(b) MCO Contract: 2.16.11.1; 2.16.11.2 PAHP Contract: 2.11.3.1 PIHP Contract: 12.5.1; 12.5.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • List of all active PIPs, including which PIPs are considered clinical and non-clinical • Documentation for all active PIPs **Evidence as Submitted by the MCE:** • Policy - Performance Improvement Project • Procedure - Performance Improvement Project • QAPI Program Description 2024 • QAPI program work plan • QAPI Program Evaluation 2024 • Evidence of All Active PIPs 2024 Quality Companion Guide • UHC LA 2024 PIP Val FV Submission Form 0315 • UHC LA 2024 PIP Val BH Submission Form 0315 • UHC LA 2024 PIP Val BH Table 8a 0315 • UHC LA 2024 PIP Val BH Table 8b 031	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• UHC LA 2024 PIP Val BH Table 8c ITM table 0315 • UHC LA 2024 PIP Val BH Table 8d to 8h QI Tools 0315 • UHC LA 2024 PIP Val CCS QI Tool 0315 • UHC LA 2024 PIP Val CCS Submission Form 0315 • UHC LA 2024 PIP Val CCS Submission Form D! 0129 • UHC LA 2024 PIP Val CCS Table 8a 0315 • UHC LA 2024 PIP Val CCS Table 8b 0315 • UHC LA 2024 PIP Val CCS Table 8c ITM Table 0315 • UHC LA 2024 PIP Val CS QI Tool 0315 • UHC LA 2024 PIP Val CS Submission Form 0315 • UHC LA 2024 PIP Val FV QI Tool 0315 • UHC LA 2024 PIP Val FV Table 8a 0315 • UHC LA 2024 PIP Val FV Table 8b 0315 • UHC LA 2024 PIP Val HIV QI Tool 0315 • UHC LA 2024 PIP Val HIV Submission Form 0315 • UHC LA 2024 PIP Val HIV Submission Form 0129 • UHC LA 2024 PIP Val HIV Table 8a 0315	

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Requirement	**Supporting Documentation**	**Score**
	• UHC LA 2024 PIP Val HIV Table 8b 0315 • UHC LA 2024 PIP Val HIV Table 8c 0315 **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	

MCE Description of Process: Review PIP Requirements
The health plan Quality Director and/or assigned staff should review the following items:

1. Contract requirements for PIPs.
2. EQRO and/or state mandated PIP requirements.
3. EQRO and/or state provided PIP template and corresponding instructions.
    a. All EQRO and/or state provided PIP instructions are to be followed and take priority over any other PIP information.
4. All previous EQRO and/or state PIP validation reports.
    a. Validation reports lend insight into how the EQRO/state views the PIP and components and their feedback in the reports should be integrated into the PIPs.

Access PIP Resources and Education Available

A. The health plan Quality Director and/or designated applicable PIP staff may:
    1. Consult with the assigned Clinical Quality Consultant from the Regulatory Adherence & Accreditation team and request a meeting to review PIP information, and schedule time for PIP reviews.
    2. Review all PIP SharePoint educational information located at: PIP Repository & Decks (sharepoint.com)
    3. Refer to external resources, listed in Quick Reference section below, such as: The Institute of Healthcare Improvement and Quality of Care published by Centers for Medicare & Medicaid Services, CMS Protocol 1.
    4. Review all EQRO and/or state PIP information, instructions, and reports.

Writing the PIP

A. The PIP writer should:
    1. Follow each step in the EQRO and/or state PIP template instructions. Note:

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Requirement	**Supporting Documentation**	**Score**
a. The instructions are specific and should be adhered to for each PIP element. b. The template should not be altered in any way. c. If the EQRO/state provides examples, use those in writing the PIP. d. When EQRO/state validation report is available, review and ensure all items noted are addressed in the PIP. e. For calculating statistical significance, if a methodology is required by the EQRO/state, then use it. If no particular methodology is required, then Chi-sq/ p-value may be used. 2. Once the PIP is complete, the writer should conduct a self-review, check for errors, and make revisions as needed. Then: a. Email a copy of the PIP to the assigned Clinical Quality Consultant and request a review. Allow at least seven business days for the review to be completed. b. After receiving feedback from PIP consultant, make applicable changes to PIP based on recommendations. i. If needed, schedule time with the Clinical Quality Consultant to discuss feedback and recommendations. c. After the review is complete, make all applicable revisions, finalize the PIP, and package it per the EQRO/state instructions and submit it to the EQRO/state. d. Once the final version has been submitted send a copy to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team. 3. When the validation report is available from EQRO/state conduct the following: a. Review the report and address all items that did not receive a Met/100% score within the PIP document. Then: i. If EQRO/state allows it, resubmit the PIP with the revisions. ii. If EQRO/state does not allow resubmission, revise PIP and save updated version in internal files so that changes are captured for the next submission due. b. Send all validation report(s) to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and includes the following elements: a. Measurement of performance using objective quality indicators.	**HSAG Required Evidence:** • QAPI program description • QAPI program work plan • QAPI program evaluation • Policies and procedures	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
b. Implementation of interventions to achieve improvement in the access to and quality of care. c. Evaluation of the effectiveness of the interventions based on the performance measures required by the State. d. Planning and initiation of activities for increasing or sustaining improvement. 42 CFR §438.330(d)(2) 42 CFR §457.1240(b) MCO Contract: 2.16.11.5 PAHP Contract: 2.11.3.2 PIHP Contract: 12.5.3	• Documentation for all active PIPs **Evidence as Submitted by the MCE:** • Policy - Performance Improvement Project • Procedure - Performance Improvement Project • QAPI Program Description 2024 • QAPI program work plan • QAPI Program Evaluation 2024 • Evidence of BH PIP Objective Quality Indicators • Evidence of CCS PIP Objective Quality Indicators • Evidence of CS PIP Objective Quality Indicators • Evidence of FV PIP Objective Quality Indicators • Evidence of HIV PIP Objective Quality Indicators **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	

MCE Description of Process: Review PIP Requirements
The health plan Quality Director and/or assigned staff should review the following items:

5. Contract requirements for PIPs.
6. EQRO and/or state mandated PIP requirements.
7. EQRO and/or state provided PIP template and corresponding instructions.
    a. All EQRO and/or state provided PIP instructions are to be followed and take priority over any other PIP information.
8. All previous EQRO and/or state PIP validation reports.

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Requirement	**Supporting Documentation**	**Score**

a. Validation reports lend insight into how the EQRO/state views the PIP and components and their feedback in the reports should be integrated into the PIPs.

Access PIP Resources and Education Available

B. The health plan Quality Director and/or designated applicable PIP staff may:
1. Consult with the assigned Clinical Quality Consultant from the Regulatory Adherence & Accreditation team and request a meeting to review PIP information, and schedule time for PIP reviews.
2. Review all PIP SharePoint educational information located at: PIP Repository & Decks (sharepoint.com)
3. Refer to external resources, listed in Quick Reference section below, such as: The Institute of Healthcare Improvement and Quality of Care published by Centers for Medicare & Medicaid Services, CMS Protocol 1.
4. Review all EQRO and/or state PIP information, instructions, and reports.

Writing the PIP

B. The PIP writer should:
1. Follow each step in the EQRO and/or state PIP template instructions. Note:
   a. The instructions are specific and should be adhered to for each PIP element.
   b. The template should not be altered in any way.
   c. If the EQRO/state provides examples, use those in writing the PIP.
   d. When EQRO/state validation report is available, review and ensure all items noted are addressed in the PIP.
   e. For calculating statistical significance, if a methodology is required by the EQRO/state, then use it. If no particular methodology is required, then Chi-sq/ p-value may be used.
2. Once the PIP is complete, the writer should conduct a self-review, check for errors, and make revisions as needed. Then:
   a. Email a copy of the PIP to the assigned Clinical Quality Consultant and request a review. Allow at least seven business days for the review to be completed.
   b. After receiving feedback from PIP consultant, make applicable changes to PIP based on recommendations.
      i. If needed, schedule time with the Clinical Quality Consultant to discuss feedback and recommendations.
   c. After the review is complete, make all applicable revisions, finalize the PIP, and package it per the EQRO/state instructions and submit it to the EQRO/state.

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d. Once the final version has been submitted send a copy to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team. 3. When the validation report is available from EQRO/state conduct the following: a. Review the report and address all items that did not receive a Met/100% score within the PIP document. Then: i. If EQRO/state allows it, resubmit the PIP with the revisions. ii. If EQRO/state does not allow resubmission, revise PIP and save updated version in internal files so that changes are captured for the next submission due. b. Send all validation report(s) to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
8. The MCE reports the status and results of each PIP to the State as requested, but not less than once per year. 42 CFR §438.330(d)(3) 42 CFR §457.1240(b) MCO Contract: 2.16.11.6 PAHP Contract: 2.11.3.3 PIHP Contract: 12.5.4.4	**HSAG Required Evidence:** • Policies and procedures • Evidence of annual submission of all PIPs to the State **Evidence as Submitted by the MCE:** • Policy - Performance Improvement Project • Procedure - Performance Improvement Project • Evidence Of Annual Submission of PIPs to the State	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Review PIP Requirements The health plan Quality Director and/or assigned staff should review the following items: 9. Contract requirements for PIPs. 10. EQRO and/or state mandated PIP requirements. 11. EQRO and/or state provided PIP template and corresponding instructions. a. All EQRO and/or state provided PIP instructions are to be followed and take priority over any other PIP information. 12. All previous EQRO and/or state PIP validation reports.		

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Requirement	**Supporting Documentation**	**Score**

a. Validation reports lend insight into how the EQRO/state views the PIP and components and their feedback in the reports should be integrated into the PIPs.

Access PIP Resources and Education Available

C. The health plan Quality Director and/or designated applicable PIP staff may:
1. Consult with the assigned Clinical Quality Consultant from the Regulatory Adherence & Accreditation team and request a meeting to review PIP information, and schedule time for PIP reviews.
2. Review all PIP SharePoint educational information located at: PIP Repository & Decks (sharepoint.com)
3. Refer to external resources, listed in Quick Reference section below, such as: The Institute of Healthcare Improvement and Quality of Care published by Centers for Medicare & Medicaid Services, CMS Protocol 1.
4. Review all EQRO and/or state PIP information, instructions, and reports.

Writing the PIP

C. The PIP writer should:
1. Follow each step in the EQRO and/or state PIP template instructions. Note:
   a. The instructions are specific and should be adhered to for each PIP element.
   b. The template should not be altered in any way.
   c. If the EQRO/state provides examples, use those in writing the PIP.
   d. When EQRO/state validation report is available, review and ensure all items noted are addressed in the PIP.
   e. For calculating statistical significance, if a methodology is required by the EQRO/state, then use it. If no particular methodology is required, then Chi-sq/ p-value may be used.
2. Once the PIP is complete, the writer should conduct a self-review, check for errors, and make revisions as needed. Then:
   a. Email a copy of the PIP to the assigned Clinical Quality Consultant and request a review. Allow at least seven business days for the review to be completed.
   b. After receiving feedback from PIP consultant, make applicable changes to PIP based on recommendations.
      i. If needed, schedule time with the Clinical Quality Consultant to discuss feedback and recommendations.
   c. After the review is complete, make all applicable revisions, finalize the PIP, and package it per the EQRO/state instructions and submit it to the EQRO/state.

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Requirement	**Supporting Documentation**	**Score**
d. Once the final version has been submitted send a copy to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team. 3. When the validation report is available from EQRO/state conduct the following: a. Review the report and address all items that did not receive a Met/100% score within the PIP document. Then: i. If EQRO/state allows it, resubmit the PIP with the revisions. ii. If EQRO/state does not allow resubmission, revise PIP and save updated version in internal files so that changes are captured for the next submission due. b. Send all validation report(s) to the Clinical Quality Consultant on the Regulatory Adherence & Accreditation team.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Critical Incidents		
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). 42 CFR §438.330(b)(5)(ii) 42 CFR §441.302 42 CFR §441.730(a) 42 CFR §457.1240(b) MCO Contract: 2.16.19 PAHP Contract: None PIHP Contract: 12.4.2.2	**HSAG Required Evidence:** • Policies and procedures • QAPI program description • QAPI program work plan • QAPI program evaluation • Three examples of critical incident reports • Committee meeting minutes • Provider remediation plan template(s) **Evidence as Submitted by the MCE:** • N/A	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: N/A, UHCCP LA does not have LTSS.		
HSAG Findings: 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.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
QAPI Program Reviews, Analysis, and Evaluation		
10. The MCE develops a process to evaluate the impact and effectiveness of its QAPI Program. The QAPI program evaluation includes: a. The performance on the measures on which it is required to report. b. The outcomes and trended results of each PIP. c. The results of any efforts to support community integration for members using LTSS. MCO: a. *The MCO's governing body shall oversee and evaluate the impact and effectiveness of the QAPI Program.* 42 CFR §438.330(e) 42 CFR §457.1240(b) 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	**HSAG Required Evidence:** • Committee meeting minutes (with discussion of QAPI evaluation) **Evidence as Submitted by the MCE:** • QAPI Agenda and Meeting Minutes Q1 2024 • QAPI Agenda and Meeting Minutes Q2 2024 • QAPI Agenda and Meeting Minutes Q3 2024 • QAPI Agenda and Meeting Minutes Q4 2024 • QAPI program evaluation **Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UHCCP LA regularly evaluates the impact and effectiveness on its QAPI Program on a quarterly and annual process. The evaluation incorporates review of performance measures, and the outcomes and trends of each PIP. This evaluation is presented annually at the QMC meeting.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
11. QAPI Committee Requirements: MCO: a. *The MCO forms a QAPI Committee that at a minimum includes:*	**HSAG Required Evidence:** • QAPI committee meeting minutes **Evidence as Submitted by the MCE:** • QAPI Agenda and Meeting Minutes Q2	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
i. *The MCO's Medical Director who must serve as either the chairman or co-chairman;* ii. *The MCO's Behavioral Health Director;* iii. *Substantial involvement of medical and behavioral health providers serving the MCO's Enrollees;* iv. *Appropriate MCO medical and behavioral health staff representing the various departments of the organization; and* v. *An Enrollee representative(s) and/or advocate(s).* PAHP: a. *The PAHP shall form a QAPI Committee that shall, at a minimum include:* i. *The Dental Director who must serve as either the chairman or co-chairman;* ii. *Appropriate PAHP staff representing the various departments of the organization who will have membership on the committee; and* iii. *The PAHP shall include an enrollee advocate representative on the QAPI Committee.* PIHP: a. *The PIHP shall form a QAPI committee that shall, at a minimum include:* i. *The PIHP's Medical Director, who must serve as the chair or co-chair and* ii. *Appropriate PIHP staff representing the various departments of the PIHP organization including but not limited to grievance and appeal staff and*		

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Requirement	**Supporting Documentation**	**Score**
corporate compliance administrator responsible for fraud, waste and abuse activities. MCO Contract: 2.16.4 PAHP Contract: 2.11.2 PIHP Contract: 12.2.1		
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
12. QAPI Committee Responsibilities: MCO: a. *The QAPI Committee shall meet on at least a quarterly basis. Its responsibilities shall include:* i. *Direct and review quality management/quality improvement (QM/QI) activities and the QAPI Program overall;* ii. *Ensure that QAPI activities take place throughout the MCO's organization and ensure that providers are involved in the QAPI Program;* iii. *Review and evaluate results of the QM/QI activities, recommend policy decisions, and suggest new and/or improved QM/QI activities;* iv. *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;* v. *Designate evaluation and study design procedures;*	**HSAG Required Evidence:** • Policies and procedures • QAPI committee meeting minutes • Evidence of submission to the State • Evidence of working with other Contractor staff and Subcontractors • Evidence of updates to the Provider Manual • Evidence of provider network performance reviews • Evidence of provider quality performance measure profiling • Evidence of periodic reviews of members' service utilization patterns **Evidence as Submitted by the MCE:** • Policy - Clinical Services Medical Management Operational Policy 2024	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
vi. *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;* vii. *Report findings to appropriate executive authority, staff, and departments within the MCO's organization;* viii. *Direct and analyze periodic reviews of Enrollees' service utilization patterns;* ix. *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;* x. *Report an evaluation of the impact and effectiveness of the QAPI Program to LDH annually;* xi. *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;* xii. *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* xiii. *Update provider manuals and other relevant clinical content on a periodic basis as often as*	• Evidence of updates to Provider Manual 20240925 LA redline • Evidence of Confirmation of LDH Submission of QAPI Meeting Minutes • QAPI Program Description • QAPI Program Work Plan • 2024 NET 1-3 Report Final NQOC approved • Evidence of participation in LDH Quality Meeting • Evidence of provider evidence network performance reviews - Service Quality Improvement Subcommittee_Agenda_Q4 2024 • Evidence of Program Evaluation Review - QMC Agenda _2024 Q1 • QAPI Agenda and Meeting Minutes Q1 • QAPI Agenda and Meeting Minutes Q2 • QAPI Agenda and Meeting Minutes Q3 • QAPI Agenda and Meeting Minutes Q4 **Additional Documentation:** • XII.12 vii and xii 2024 C_S QI PHM Program Work Plan • XII.12 xi Evidence of participation in LDH Quality Meeting • XII. 12 iv Evidence of QAPI Program_Description_2024 A	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
determined necessary by the committee chairperson. PAHP: a. *The QAPI Committee shall:* i. *Meet on a quarterly basis;* ii. *Direct and review quality improvement (QI) activities;* iii. *Ensure that QAPI activities are implemented throughout the PAHP;* iv. *Review and suggest new and/or improved QI activities;* v. *Direct task forces and/or committees to review areas of concern in the provision of healthcare services to enrollees;* vi. *Designate evaluation and study design procedures;* vii. *Conduct individual primary dental provider (PDP) and group practice quality performance measure profiling;* viii. *Report findings to appropriate executive authority, staff, and departments within the PAHP;* ix. *Direct and analyze periodic reviews of enrollees' service utilization patterns;* x. *Maintain minutes of all committee and sub-committee meetings and submit a summary of the meeting minutes to LDH upon request; and* xi. *Ensure that a QAPI Committee designee attends LDH Quality Committee meetings.*	• XII. 12 ix Evidence of QAPI Agenda and Meeting Minutes_2024 • XII. 12 vi. Evidence of Review of Provider Network Performance_2024 NET 1-3 Report Final NQOC approved • XII. 12 vii. Evidence of QAPI Agenda and Meeting Minutes_2024 • XII. 12 viii Evidence of Direct and analyze period reviews of Enrollees' service utilization • XII. 12 xiii Evidence of Updated Provider Manua_2024-PATH-Reference-Guide • XII.12 v Evidence of evaluation and study design procedures	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
PIHP: a. *QAPI committee responsibilities shall include:* i. *Directing and reviewing QI activities;* ii. *Ensuring that QAPI activities take place throughout the organization;* iii. *Suggesting new and/or improved QI activities;* iv. *Directing task forces/committees to review areas of concern in the provision of behavioral healthcare services to members;* v. *Conducting provider quality performance measure profiling;* vi. *Reporting findings to appropriate executive authority, staff, and departments within the PIHP;* vii. *Directing and analyzing periodic reviews of members' service utilization patterns; and* viii. *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.* MCO Contract: 2.16.5 PAHP Contract: 2.11.2.2 PIHP Contract: 12.2.2		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: The QAPI Committee meets quarterly to oversee and enhance quality management and improvement activities across the MCO. Key responsibilities include: Directing and reviewing QM/QI activities and the overall QAPI Program. Ensuring organization-wide QAPI activities and provider involvement. Evaluating QM/QI results, recommending policies, and suggesting improvements. Creating task forces to address healthcare service concerns and ensuring follow-up. Designating evaluation and study procedures. Reviewing provider network performance to identify and address patterns. Reporting findings to executive authority and relevant departments. Analyzing Enrollees' service utilization patterns periodically. Maintaining and submitting meeting minutes to LDH, ensuring availability for reviews. Reporting the QAPI Program's impact and effectiveness to LDH annually. Participating in LDH's Quality Committee meetings as required. Collaborating with staff and subcontractors to address quality concerns. Updating provider manuals and clinical content as necessary.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
13. QAPI Plan Requirements: MCO: a. *The QAPI Committee shall develop and implement a written QAPI Plan that incorporates the strategic direction provided by the governing body.* b. *The QAPI Plan shall be submitted to LDH or its designee as part of Readiness Review and annually* c. *The QAPI Plan, at a minimum, shall:*	**HSAG Required Evidence:** • QAPI Plan • Evidence of submission to the State **Evidence as Submitted by the MCE:** • QAPI Program Description • QAPI program evaluation • QAPI Plan (0136) Submission 03282024 • LA Acute Care Provider Manual 08272024	☒ Met ☐ Not Met ☐ NA

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;* ii. *Include processes and metrics to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the Contractor staff assigned to the QAPI Program, their specific training, their organizational structure, and their responsibilities;* iv. *Describe the role of Network Providers and Enrollees in providing input to the QAPI Program;* v. *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* vi. *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.* PAHP: a. *The QAPI Committee shall develop and implement a written QAPI plan which incorporates the strategic direction.* b. *The QAPI plan shall be submitted to LDH annually, and prior to revisions.* c. *The QAPI plan, at a minimum, shall:* i. *Reflect a coordinated strategy to implement the QAPI Program, including planning, decision making, intervention and assessment of results;*	**Additional Documentation:** • XII. Evidence of 2024 QAPI Program Evaluation	

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
ii. *Include processes to evaluate the impact and effectiveness of the QAPI Program;* iii. *Include a description of the PAHP staff assigned to the QAPI Program, their specific training, how they are organized, and their responsibilities; and* iv. *Describe the role of providers in giving input to the QAPI Program.* PIHP: a. *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).* b. *The QAPI program description at a minimum, shall:* i. *Include a description of the Contractor staff assigned to the QAPI program, their specific training, how they are organized, and their responsibilities.* ii. *Include the methodology utilized for collecting data and describe the methods for ensuring data collected and reported to LDH is valid and accurate.*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
iii. *Specify the remediation actions that will be implemented when system performance is less than the required threshold.* iv. *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.* v. *Describe how the Contractor will obtain feedback from providers and members.* vi. *Describe how the Contractor will collect and utilize data on race, ethnicity, gender, age, primary language, and geography to identify potential health disparities.* vii. *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.* c. *The QAPI work plan at a minimum shall:* *Include objectives for the Contract year, inclusive of associated action steps and timelines.* i. *Include metrics and associated benchmarks for the wraparound agency scorecard.* ii. *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*		

Standard XII—Quality Assessment and Performance Improvement		
Requirement	**Supporting Documentation**	**Score**
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. iii. *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.* MCO Contract: 2.16.6 PAHP Contract: 2.11.2.3 PIHP Contract: 12.2.3		
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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

Total Score ÷ Total Applicable	=	**100%**

Standard XIII—Grievance and Appeal Systems

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Grievance System General Requirements		
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. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.3	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook **Evidence as Submitted by the MCE:** • A&G Member Policy, Policy Definitions, Grievance, page 2-3 • UHC Member Handbook Grievance Section pg. 71-72	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare adheres to the federal definition of a grievance as defined in the appeals and grievances policy.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
2. A member may file a grievance with the MCE at any time. a. With the written consent of the member, a provider or an authorized representative may file a grievance on behalf of a member.	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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) MCO Contract: 2.15.2.1 PAHP Contract: 2.10.2.1 PIHP Contract: 11.3.6.1	• HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy; Grievance Process; Timely Filing, page 11 • 2a. MemberConsentGrievance_2024 • 2a. UHC Member Handbook Grievance Section; pg 71	
MCE Description of Process: UnitedHealthcare, has processes in place for accepting member grievances both verbally and in writing at any time from a member or authorized representative with the members' written consent. This approach helps ensure that members can express their concerns or complaints regarding their services, coverage, or any other issues they may encounter.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The member may file a grievance either orally or in writing. 42 CFR §438.228 42 CFR §438.402(c)(3)(i) 42 CFR §457.1260(b)(1) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the system demonstration **Evidence as Submitted by the MCE:** • A&GMemberPolicy; Grievance Process; Filing Method, page 11 • UHC Member Handbook; How to file a grievance or appeal section; page 72	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	Additional Documentation: • UHC Member Handbook Grievance Section; page 72 • UHC Member Handbook; Grievance and Appeals form; page 75 • Address to mail A&G form is on both pages 72 & 75	
MCE Description of Process: UnitedHealthcare accepts member grievances verbally or in writing at any time.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Grievances		
4. The MCE acknowledges receipt of each grievance. MCO and PAHP: a. *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.* PIHP: a. *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.* 42 CFR §438.228	**HSAG Required Evidence:** • Policies and procedures • Grievance acknowledgment notice template • Tracking and reporting mechanisms • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • 4a A&GMemberPolicy; Grievance Process; Timely Filing, page 11 • GrievanceAck_2024 • MemberHandbook_2024; page 72 • Ack_LTR_Req_Report_Grievance	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.2.2 PAHP Contract: 2.10.2.2 PIHP Contract: 11.4.1.1.1		
MCE Description of Process: As soon as a grievance is received, it is promptly entered into our Escalation Tracking System. The Analyst will take the necessary steps to create an acknowledgment letter within 5 business days of receipt. This letter confirms receipt of the grievance and summarizes the issue. Additionally, it will include an estimated timeline for the resolution.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. The MCE ensures that the individuals who make decisions on grievances are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual. 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: i. A grievance regarding denial of expedited resolution of an appeal. ii. A grievance that involves clinical issues. c. Who take into account all comments, documents, records, and other information submitted by the member or their representative. 42 CFR §438.228 42 CFR §438.406(b)(2) 42 CFR §457.1260(d)	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of grievance staff members, including credentials • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • 5 a, bi, bii, c A&GMemberPolicy; Grievance Process; Reviewer, page 11-12 • QOC_LAOrgChart • GrievanceStaff_LA **Additional Documentation:** • XIII.5_A&Gcredentials	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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		
MCE Description of Process: UnitedHealthcare grievance process emphasizes impartiality, appropriate clinical expertise, and a conduct a thorough review to support member rights and address member concerns completely. The individuals who make decisions aren't involved in any previous level of review the reviewer also considers all pertinent documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: 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. *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.* PIHP Standard Grievances a. *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.* 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(1) 42 CFR §457.1260(e)(12)	**HSAG Required Evidence:** • Policies and procedures • Grievance resolution notice template or oral notification script • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy; Grievance Process; Standard Resolution Time, page 12 • GrievanceResolve_2024 • GrievanceQOCResolve_2024 • Resolve_LTR_Req_Report_Grievance	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.15.2.3 PAHP Contract: 2.10.2.3 PIHP Contract: 11.4.8.1.1	**Additional Documentation:** • SXIII.6.7_Resolve_LTR_Req_Report_Grievanc	
MCE Description of Process: UnitedHealthcare resolves and provides notice of a grievance resolution as expeditiously as the member's health condition necessitates, but no longer than 90 calendar days from the date of receipt.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
7. The MCE may extend the timeframe for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or 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. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.4 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of a grievance with extensions with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • Resolve_LTR_Req_Report_Grievance **Additional Documentation:** • SXIII.6.7_Resolve_LTR_Req_Report_Grievance	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare resolves and provides written notice of a grievance resolution as expeditiously as the member's health condition necessitates, but no longer than 90 calendar days from the date of receipt. Per federal regulation grievance resolution and notice has to be provided within 90 calendar days. In 2024, UnitedHealthcare did not seek an extension on any grievance from LDH.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit evidence of a policy or procedure that demonstrated the MCE had a process to extend the time frame for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or 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.		
Required Actions: The MCE must submit evidence of compliance with the requirements that the MCE may extend the time frame for resolving grievances by up to 14 calendar days if: a. The member requests the extension; or 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.		
8. If the MCE extends the grievance resolution timeframe not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. 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. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.2.5 PAHP Contract: 2.10.2.5 PIHP Contract: 11.4.8.4.2	**HSAG Required Evidence:** • Policies and procedures • Grievance extension template letter • Two examples of grievances with extensions with oral and written notice • HSAG will also use the results of the Grievances File Review **Evidence as Submitted by the MCE:** • Evidence was not submitted by the MCE.	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare resolves and provides notice of a grievance resolution as expeditiously as the member's health condition necessitates, but no longer than 90 calendar days from the date of receipt. Federal regulations require grievance resolution and notice within 90 calendar days. UnitedHealthcare would not take an extension on a grievance.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit evidence of compliance with the requirements of this element.		
Required Actions: The MCE must submit evidence of compliance that if the MCE extends the grievance resolution time frame not at the request of the member, it completes all of the following: a. Makes reasonable efforts to give the member prompt oral notice of the delay. b. Within two calendar days, gives the member written notice of the reason for the decision to extend the time frame and informs the member of the right to file a grievance if he or she disagrees with that decision.		
Appeals General Requirements		
9. The MCE defines an appeal as a review by the MCE of an ABD. 42 CFR §438.228 42 CFR §438.400(b) 42 CFR §457.1260(a)(2)(ii) MCO Contract: Part 1: Glossary and Acronyms PAHP Contract: 7.1 PIHP Contract: 11.2.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Definitions, Appeal, page 2 • MemberHandbook; Adverse benefit determination, appeal and grievance, adverse benefit determination, page 70 • UHC Provider Manual Appeal and grievances standard definitions and process requirements section pg. 99	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare adheres to the federal definition of an appeal.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
10. The MCE has only one level of appeal for members. 42 CFR §438.228 42 CFR §438.402(b) 42 CFR §457.1260(b)(1) MCO Contract: None PAHP Contract: None PIHP Contract: 11.1.2	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, General, page 3 • UHC Member Handbook Appeal section pg. 70 • UHC Provider Manual Appeal and grievances standard definitions and process requirements section pg. 99 and enrollee appeals section pg. 108	☐ Met ☐ Not Met ☒ NA
MCE Description of Process: UnitedHealthcare currently offers only a single level of appeal. Members must submit their appeal within 60 calendar days after receiving an adverse benefit determination.		
HSAG Findings: 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.		
Required Actions: The MCE should await direction from LDH regarding whether modifications will be made to the informal reconsideration process.		
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,	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
physical or mental health, or ability to attain, maintain, or regain maximum function. a. The MCE ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. 42 CFR §438.228 42 CFR §438.410(a-b) 42 CFR §457.1260(f) 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	**Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Expedited Resolution Time (Pre-service), page 5 • 11 a A&GMemberPolicy, Policy Provisions, Appeal Process, Punitive or retaliatory action, page 7 • 11a UHC Member Handbook Appeals section pg. 70. • 11a UHC Provider Manual Enrollee appeals section pg. 108	
MCE Description of Process: UnitedHealthcare establishes and maintains an expedited review process for appeals when it is determined that a standard resolution could seriously jeopardize a member's life, health, or ability to function. This process can be initiated by either the member or the provider acting on the member's behalf. Additionally, UnitedHealthcare ensures that no punitive action is taken against providers who request an expedited resolution or support a member's appeal, thereby fostering an environment where members' urgent needs can be addressed effectively.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.228 42 CFR §438.402(c)(2)(ii) 42 CFR §457.1260(b)(1)	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • Member materials, such as the member handbook • ABD notice template • Provider materials, such as the provider manual	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.15.3.1.1 PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.3.5.3	**Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Timely Filing, page 4 • MemberHandbook; Adverse benefit determination, appeal and grievance, appeal, page 70 • UHC Provider Manual Appeal and grievances standard definitions and process requirements section pg. 99 and Enrollee appeals section pg. 108 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template • LA_Narrative_Standard12_Tracking	
MCE Description of Process: UnitedHealthcare allows members or an authorized representative to file standard and expedited appeals within 60 calendar days from the date of the notice.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
13. The member may file an appeal orally or in writing. a. With the written consent of the member, a provider or an authorized representative may request an appeal on behalf of the member. 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) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Member consent form template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Filing Method, page 4 • MemberConsentAppeal_2024 • 13a A&GMemberPolicy, Policy Provisions, Appeal Process, Filing Method, page 4 • 13a UHC Member Handbook; how to file a grievance or appeal section pg. 72	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare accepts member appeals verbally or in writing from the member or an authorized representative with the member's written consent. Appeal submissions are received via call center, mail, email, portal, or fax.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Handling of Appeals		
14. If the MCE denies a request for expedited resolution of an appeal, it: a. Transfers the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).	**HSAG Required Evidence:** • Policies and procedures • Denied expedited resolution letter template • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
b. Follows the requirements in 42 CFR §438.408(c)(2), including: i. Makes reasonable efforts to give the member prompt oral notice of the delay. 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. 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) 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	**Evidence as Submitted by the MCE:** • 14 a, bi, bii A&GMemberPolicy, Policy Provisions, Appeal Process, Extension of Resolution Time, For expedited appeals, page 6 • ExptoStandardAck_2024 **Additional Documentation:** • XIII.A&G Member Policy; page 6	
MCE Description of Process: UnitedHealthcare maintains an expedited process in which members and providers on behalf of members can request an urgent resolution. When an expedited resolution is denied, the member is given notice both telephonically and followed up with a written response within two calendar days. The written notice provides the right to file a grievance if the member does not agree with the denial to expedite.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
15. The MCE acknowledges receipt of each appeal. MCO and PAHP: a. *The MCO/PAHP shall acknowledge each appeal in writing within five (5) business days of receipt of each*	**HSAG Required Evidence:** • Policies and procedures • Appeal acknowledgment template • Tracking and reporting mechanisms	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
appeal unless the enrollee requests an expedited resolution. PIHP: a. *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.* 42 CFR §438.228 42 CFR §438.406(b)(1) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.3 PAHP Contract: 2.10.3.3 PIHP Contract: 11.4.1.1.1	• HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • 15 a A&GMemberPolicy, Policy Provisions, Appeal Process, Acknowledgement, page 5 • AppealAck_2024 • AppealAck_LTR_Req_Report	
MCE Description of Process: UnitedHealthcare acknowledges member appeals by sending a written acknowledgement letter within 5 business days of receipt of the appeal.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's Appeal & Grievance Member policy stated that the written acknowledgement letter is sent upon case entry into the tracking system within five business days.		
Required Actions: The MCE must acknowledge each appeal in writing within five business days of receipt of each appeal unless the enrollee requests an expedited resolution.		
16. The MCE ensures that the individuals who made decisions on appeals are individuals: a. Who are not involved in any previous level of review or decision-making, nor a subordinate of any such individual.	**HSAG Required Evidence:** • Policies and procedures • Organizational chart of appeal staff members, including credentials • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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: i. An appeal of a denial that is based on lack of medical necessity. ii. An appeal that involves clinical issues. 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. 42 CFR §438.228 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	**Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, General, page 3 • 16 a, bi, bii, c A&GMemberPolicy, Policy Provisions, Appeal Process, Reviewer, page 5 • AppealsStaff_LA • ORG-Appeal MD • ORG-Clinical Appeal Nurses	
MCE Description of Process: UnitedHealthcare appeal process emphasizes impartiality, appropriate clinical expertise, and will conduct a thorough review to support member rights and address member concerns completely. The individuals who make decisions aren't involved in any previous level of review; the reviewer also considers all pertinent documentation.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

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Requirement	**Supporting Documentation**	**Score**
17. The MCE treats oral inquiries seeking to appeal an ABD as appeals. 42 CFR §438.228 42 CFR §438.406(b)(3) 42 CFR §457.1260(d) MCO Contract: None PAHP Contract: 2.10.3.1.1 PIHP Contract: 11.4.2.1	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Timely Filing, page 4 • UHC Member Handbook Appeal section pg. 70	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: Members can submit their appeals either verbally (via phone) or in writing (through mail, fax, or online submission).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 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. 42 CFR §438.228 42 CFR §438.406(b)(4) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.3.1.4; 2.15.3.4.3	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Expedited Resolution Time (Pre-service), page 5	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PAHP Contract: 2.10.3.1.3 PIHP Contract: 11.4.2.2	• AppealAck_2024 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template • LA Appeals Grievances and State Fair Hearings_Member Services – All pages	
MCE Description of Process: UnitedHealthcare allows the members a reasonable opportunity to present information to be considered during the appeal review in person and in writing. UnitedHealthcare informs the member of the limited time available in advance of the resolution timeframe in the case of an expedited resolution. The member is informed of the resolution timeframe via the acknowledge letter and verbally if the member submitted the appeal orally or as expedited by the call center and or the resolving analyst.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
19. The MCE provides the member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCE (or at the direction of the MCE) in connection with the appeal of the ABD. 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). MCO and PAHP:	**HSAG Required Evidence:** • Policies and procedures • Member communications, such as ABD notice template, member acknowledgment template, and/or call script • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:**	☐ Met ☒ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
a. *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.* 42 CFR §438.228 42 CFR §438.406(b)(5) 42 CFR §438.408(b-c) 42 CFR §457.1260(d) MCO Contract: 2.15.1.6; 2.15.3.1.5 PAHP Contract: 2.10.1.6 PIHP Contract: 11.4.2.3	• 19a A&GMemberPolicy, Policy Provisions, Appeal Process, Evidence, page 5 • AppealAck_2024 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template • Member Rights and Responsibilities_Member Services – All pages	
MCE Description of Process: Members, or their designated representatives, have the right to request a complete copy of their case file, which includes all relevant documents and records that pertain to their appeal.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's policies and procedures did not include, for State fair hearings, the requirement that upon request, the MCE 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 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. Additionally, the member notices did not inform the member of the requirements of this element.		
Required Actions: The MCE must update its policies and procedures to include, for State fair hearings, the requirement that upon request, the MCE 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 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.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Resolution and Notification of Appeals		
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. 42 CFR §438.228 42 CFR §438.408(a) 42 CFR §438.408(b)(2) 42 CFR §457.1260(e)(1-2) MCO Contract: 2.15.3.3.1 PAHP Contract: 2.10.3.7 PIHP Contract: 11.4.8.2.1	**HSAG Required Evidence:** • Policies and procedures • Tracking documentation • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Standard Resolution Time (Pre and Post-service), page 5 • AppealResolve_LTR_Req_Report_Standard 20 **Additional Documentation:** • SXIII.20_AppealResolve_LTR_Req_Report_Standard 20	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare aims to resolve expedited appeals as quickly as the member's health condition requires, but no later than **72 hours** from when the request is received. Verbal notice of the resolution to the member within a 72-hour period. UnitedHealthcare is required to resolve standard appeals and provide notice within 30 calendar days from the date the request is received.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
21. The MCE resolves expedited appeals and sends notice to the affected parties no later than 72 hours after the MCE receives the appeal. 42 CFR §438.228 42 CFR §438.408(b)(3) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.2 PAHP Contract: 2.10.4.2 PIHP Contract: 11.4.8.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Expedited Resolution Time (Pre-service), page 5 • AppealResolve_LTR_Req_Report_Urgents	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare resolves, and the resolution analyst makes reasonable efforts to provide verbal notice on expedited member appeals within 72 hours from the time the request is received.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
22. The MCE may extend the standard or expedited appeal resolution timeframes by up to 14 calendar days if: a. The member requests the extension; or 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. 42 CFR §438.228 42 CFR §438.408(c)(1) 42 CFR §457.1260(e)(1)	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Two examples of appeals with extended time frame with LDH approval • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.15.3.5.1 PAHP Contract: 2.10.2.4 PIHP Contract: 11.4.8.4	**Evidence as Submitted by the MCE:** • 22 a,b A&GMemberPolicy, Policy Provisions, Appeal Process, Extension of Resolution Time:, For standard appeals, page 5-6	
MCE Description of Process: UnitedHealthcare makes every effort to resolve standard and expedited appeal requests within required timeframes, but there are some circumstances when requesting more time to review the appeal request is in the members' best interest. UnitedHealthcare provides the member prompt oral notice and follows up with mailing written notice within 2 calendar days. In 2024 UnitedHealthcare did not request an extension from LDH on any member appeals.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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: a. Makes reasonable efforts to give the member prompt oral notice of the delay. 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. c. Resolves the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR §438.228 42 CFR §438.408(c)(2) 42 CFR §457.1260(e)(1-2) 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	**HSAG Required Evidence:** • Policies and procedures • Two examples of appeals with extended time frame with oral and written notice • Appeal extension template letter • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • 23 a,b,c A&GMemberPolicy, Policy Provisions, Appeal Process, Expedited Resolution Time (Pre-service), page 6 • A&GMemberPolicy, Policy Provisions, Appeal Process, Extension of Resolution Time, page 5 • 23 a. AppealExtension_Case 1, ETS Case Comments, Verbal Acknowledgment; page 27	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	• 23 b. AppealExtension_Case 1; Appeal Extension Letter, page 80 • 23 c. AppealExtension_Case 1; Appeal Resolution Letter, page 85 • 23 a. AppeaExtension_Case 2; ETS Case Comments, Verbal Acknowledgement, page 8 • 23 b. AppealExtension_Case 2; Appeal Extension Letter, page 51 • 23 c. AppealExtension_Case 2; Appeal Resolution Letter, page 56	
MCE Description of Process: UnitedHealthcare makes every effort to resolve standard and expedited appeal requests within required timeframes, but there are some circumstances when requesting more time to review the appeal request is in the members' best interest. UnitedHealthcare provides the member prompt oral notice and follows up with mailing written notice within 2 calendar days.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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). 42 CFR §438.228 42 CFR §438.408(c)(3) 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(3) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.12 PIHP Contract: 11.4.8.4.3.1	**HSAG Required Evidence:** • Policies and procedures • Tracking and reporting mechanisms • Member materials, such as the member handbook • Appeal notice template for untimely appeal resolution • HSAG will use the Universe File to evaluate timeliness • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	Evidence as Submitted by the MCE: • A&GMemberPolicy, Policy Provisions, Appeal Process, Failure to Make a Timely Appeal Decision and Special Handling of Pharmacy Appeals, page 6 • UHC Member Handbook State Fair Hearings Section pg. 73 • AppealUntimely_2024 **Additional Documentation:** • SXIII.24_AppealAck_2024	
MCE Description of Process: Members may request a state fair hearing within 120 calendar days of receiving notification that UnitedHealthcare is upholding an adverse benefit determination. A request for a state fair hearing can also be made if UnitedHealthcare fails to take action within the required timeframes. Before requesting a state fair hearing, members must first exhaust the internal appeal process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
25. For all appeals, the MCE provides written notice of the appeal resolution that includes: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. The right to request a SFH, and how to do so. ii. The right to request and receive benefits while the hearing is pending, and how to make the request.	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • 25 a, bi, bii, biii, A&GMemberPolicy, Policy Provisions, Appeal Process, Resolution: Notice of Appeal Resolution, page 6	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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. MCO: a. *The MCO shall provide the enrollee with a written notice of appeal resolution using a template approved by LDH in writing.* b. *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.* c. *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.* PAHP: a. *The PAHP shall provide the enrollee with a written notice using a notice of appeal resolution template approved by LDH.* b. *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.* c. *The PAHP shall inform the enrollee of their right to seek a state fair hearing if the enrollee is not satisfied*	• AppealUphold_2024 • AppealOverturn_2024	

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Requirement	**Supporting Documentation**	**Score**
with the PAHP's decision in response to an appeal, and the process for doing so. 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) MCO Contract: 2.15.3.6 PAHP Contract: 2.10.5 PIHP Contract: 11.4.13		
MCE Description of Process: UnitedHealthcare provides notifications to the member in a way that is linguistically and culturally appropriate, ensuring clear understanding for individuals from diverse backgrounds. If the appeal is not resolved in favor of the member, the notification will outline the members right to State Fair Hearing. Members are informed of their right to escalate the issue to a state fair hearing. The members' rights indicate that if the decision is upheld during the fair hearing, the member may be responsible for the costs associated with the services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
26. For notice of an expedited appeal resolution, the MCE makes reasonable efforts to provide oral notice. MCO and PAHP: a. *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.* 42 CFR §438.228 42 CFR §438.408(d)(2)(ii) 42 CFR §457.1260(e)(1) MCO Contract: 2.15.3.4.5 PAHP Contract: 2.10.4.5	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Expedited Resolution Time (Pre-service), page 5 • A&GMemberPolicy, Policy Provisions, Appeal Process, Resolution: Oral Notification (Expedited Appeals), page 6	☐ Met ☒ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
PIHP Contract: 11.4.13.2	• 26 a A&GMemberPolicy, Policy Provisions, Appeal Process, Extension of Resolution Time, For expedited appeals, page 6	
MCE Description of Process: In the event of an expedited appeal the member and any affected parties will be notified telephonically within 72 hours and followed up with a written resolution letter within 2 calendar days.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's LA Member Appeal, State Fair Hearing, and Grievance policy indicated that for an expedited appeal resolution, oral and written notification of the decision are provided within 72 hours of the decision.		
Required Actions: The MCE must update its policies and procedures to include the requirement that in the case of an expedited appeal denial, the MCE shall provide oral notice to the enrollee by close of business on the day of resolution and written notice to the enrollee within two calendar days of the disposition.		
State Fair Hearings and State External Review		
27. The member may request a SFH only after receiving notice that the MCE is upholding the ABD related to the appeal. a. With the written consent of the member, a provider or an authorized representative may request a SFH on behalf of the member. 42 CFR §438.228 42 CFR §438.408(f)(1)(i) 42 CFR §457.1260(e)(5) Contract H.4.03 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	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice **Evidence as Submitted by the MCE:** • 27a UHC Member Handbook State Fair Hearings section pg. 73 • A&GMemberPolicy, Policy Provisions, State Fair Hearing Process, Access to State Fair Hearing, page 7 • AppealUphold_2024	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: AppealUphold_2024 advises the member of their next level rights after receiving an uphold determination.		

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Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
28. The member has *120 calendar days* from the date of the MCE's notice of appeal resolution to request an SFH. MCO: a. *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.* PAHP: a. *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.* PIHP: a. *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*	**HSAG Required Evidence:** • Policies and procedures • Appeal resolution notice template • Member materials, such as the member handbook and/or ABD notice • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • 28a UHC Member Handbook State Fair Hearings section pg. 73 • A&GMemberPolicy, Policy Provisions, State Fair Hearing Process; Timely Filing, page 7 • AppealUphold_2024; State Fair Hearing; page 5	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
twenty (120) calendar days from the date of the PIHP's notice of resolution. 42 CFR §438.228 42 CFR §438.408(f)(2) 42 CFR §457.1260(e)(5) MCO Contract: 2.15.4.1 PAHP Contract: 2.10.6.1 PIHP Contract: 11.4.14.2		
MCE Description of Process: UnitedHealthcare accepts requests for state fair hearings within 120 calendar days of receiving notice that UnitedHealthcare is upholding the initial adverse benefit determination or if we the plan fails to act within the required timeframes. The member must first exhaust the appeal process prior to requesting a state fair hearing.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Continuation of Benefits		
29. The MCE continues the member's benefits if all of the following occur: a. The member files the request for an appeal timely (within 60 calendar days from the date on the ABD notice). b. The appeal involves the termination, suspension, or reduction of previously authorized services. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member timely files for continuation of benefits.	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • 29 a,b,c,d,e A&GMemberPolicy, Policy Provisions, Appeal Process, Continuation of benefits, page 4 • A&GMemberPolicy, Policy Provisions, State Fair Hearing Process; Continuation of Benefits, page 7	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCO/PAHP/PIHP: a. *Within ten (10) calendar days of the MCO/PAHP mailing the notice of ABD.* *Timely files* means on or before the later of the following: within 10 calendar days of the MCE sending the notice of ABD, or the intended effective date of the MCE's proposed ABD. 42 CFR §438.228 42 CFR §438.420(a-b) MCO Contract: 2.15.3.2.1 PAHP Contract: 2.10.3.4 PIHP Contract: 11.6.2	• AppealUphold_2024; State Fair hearing, page 6 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template	
MCE Description of Process: UnitedHealthcare will continue the member's benefits if the following conditions are met: the member timely files a request for an appeal within 60 calendar days from the date of the adverse benefit determination (ABD) notice; the appeal concerns the termination, suspension, or reduction of previously authorized services; those services were ordered by an authorized provider; the original authorization period has not expired; and the member timely requests continuation of benefits, which must occur on or before the later of 10 calendar days after UnitedHealthcare sends the ABD notice or the intended effective date of the proposed ABD. Additionally, the member or an authorized representative (with the member's written consent) can request continuation of benefits while the appeal or state fair hearing is pending, provided all timely filing requirements are satisfied.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: 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: a. The member withdraws the appeal or request for SFH.	**HSAG Required Evidence:** • Policies and procedures • ABD notice template • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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. c. A SFH office issues a hearing decision adverse to the member. MCO and PAHP: a. Appeals i. *The time period or service limits of a previously authorized service has been met.* 42 CFR §438.228 42 CFR §438.420(c) 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	**Evidence as Submitted by the MCE:** • 30 a,b,c A&GMemberPolicy, Policy Provisions, Appeal Process, Continuation of benefits, page 4 • 30 a,b,c A&GMemberPolicy; page 8 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template **Additional Documentation:** • XIII.30a i_A&G Member Policy; Continuation of Benefits; page 4	
MCE Description of Process: If, at the request of the member, UnitedHealthcare continues or reinstates the member's benefits while the appeal or state fair hearing (SFH) is pending, those benefits will remain in place until one of the following occurs: the member withdraws the appeal or request for a SFH; the member fails to request a SFH and continuation of benefits within 10 calendar days after UnitedHealthcare sends notice of an adverse resolution to the appeal; or a SFH office issues a decision that is adverse to the member.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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	**HSAG Required Evidence:** • Policies and procedures • ABD notice template	☒ Met ☐ Not Met

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
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. 42 CFR §438.228 42 CFR §438.420(d) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.4.1	• Appeal resolution notice template • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Continuation of benefits, page 8 • AppealUphold_2024 • LA Chisholm Insufficient Information Template • LA Chisholm Member Approval Template • LA Chisholm MIOD Template • LA Chisholm NOA Template • LA NOA PDHC MMBPRV Template • LA NOA Template • LA Partial Denial NOA Template	☐ NA
MCE Description of Process: If the final resolution of the appeal or state fair hearing (SFH) is unfavorable to the member, meaning it upholds UnitedHealthcare's adverse decision, UnitedHealthcare may recover the cost of services provided to the member while the appeal was pending, but only if those services were furnished solely due to the requirements, in line with the state's usual recovery policies.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
32. If the MCE or the SFH officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCE or the State must pay for those services, in accordance with State policy and regulations.	**HSAG Required Evidence:** • Policies and procedures • Staff training materials • HSAG will also use the results of the Appeals File Review	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
42 CFR §438.228 42 CFR §438.424(b) MCO Contract: None PAHP Contract: None PIHP Contract: 11.6.5.2	**Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Effectuation, page 6	
MCE Description of Process: UnitedHealthcare is responsible for ensuring that if a decision to deny service authorization is reversed during an appeal, and the member has already received the disputed services while the appeal was pending, payment for those services will be made in accordance with state policy and regulations. Following the reversal of the appeal or state fair hearing resolution, UnitedHealthcare will update the system authorization to provide the necessary services as promptly as the member's health condition requires, but no later than 72 hours after receiving the notice of reversal. If services were provided while awaiting the outcome of the appeal, the system authorization will also be updated to approve payment for those services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Reinstatement of Services		
33. If the MCE or the SFH officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCE authorizes or provides the 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. 42 CFR §438.228 42 CFR §438.424(a) 42 CFR §457.1260(i) MCO Contract: 2.15.4.9 PAHP Contract: 2.10.6.10 PIHP Contract: 11.6.5.1	**HSAG Required Evidence:** • Policies and procedures • Tracking mechanisms • HSAG will also use the results of the Appeals File Review **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Effectuation, page 6 • A&GMemberPolicy, Louisiana State Fair Hearing Companion, Effectuation, page 11	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare ensures that if a decision to deny, limit, or delay services is reversed during an appeal or state fair hearing, the disputed services are authorized and provided promptly, in accordance with the member's health needs, and within a maximum of 72 hours from the date it receives the notice of reversal. Additionally, if services were provided while the appeal was pending, UnitedHealthcare updates the system authorization to approve payment for those services.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.228 42 CFR §438.406(a) 42 CFR §457.1260(d) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook • Example of assistance to members on filing a grievance **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Assistance, page 4 • A&GMemberPolicy, Policy Provisions, Grievance Process, Assistance, page 11 • A&GMemberPolicy, Policy Provisions, State Fair Hearing Process; Assistance, page 7 • UHC Member Handbook how to file a grievance or appeal section pg. 72 • Embrace the Gray_Member Services – All pages • LA Appeals Grievances and State Fair Hearings_Member Services – All pages • Interpreter Services - TTY, TRS, and VRS_Member Service SOP – All Pages	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
	• Interpreter Services - ULG_Member Service SOP – All Pages • LA_Assistmbr_translationAck • LA_Assistmbr_translationResolve	
MCE Description of Process: UnitedHealthcare offers reasonable assistance to members in completing forms and navigating procedural steps related to grievances and appeals. This assistance includes providing auxiliary aids and services upon request, such as interpreter services and toll-free numbers equipped with TTY/TDD and interpreter capabilities. UnitedHealthcare ensures that all members, including those with limited English proficiency, visual or communicative impairments, or physical disabilities, have equal access to and full participation in the grievance and appeals process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 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) 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	**HSAG Required Evidence:** • Policies and procedures • Mechanisms to assess reading grade level of member notices • Grievance and appeal resolution templates, including taglines • HSAG will also use the results of the Grievances and Appeals File Reviews **Evidence as Submitted by the MCE:** • A&GMemberPolicy, Policy Provisions, Appeal Process, Resolution: Notice of Appeal Resolution, page 6 • A&GMemberPolicy, Policy Provision; Grievance Process, Resolution: Notice of Grievance Disposition, page 12 • Reading_Grade_Level_Mechanism	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: UnitedHealthcare provides written notifications regarding grievance and appeal resolutions in a format and language that comply with the requirements. This includes informing the member in writing of the resolution, detailing the reasons for the decision, citing the policies that support the decision, and clearly explaining the available options.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. 42 CFR §438.10(g)(2)(xi) 42 CFR §438.228 42 CFR §438.414 42 CFR §457.1260(g) MCO Contract: 2.9.29.7 PAHP Contract: 2.6.9.13 PIHP Contract: 11.6.6.1	**HSAG Required Evidence:** • Policies and procedures • Provider manual • Provider contract • Subcontractor agreement template **Evidence as Submitted by the MCE:** • UHC Provider Manual appeals and care provider grievance section pg. 105, 106 and 107 • Provider Contract • LA Medicaid_CHIP Reg App Medical Subcontractor 06.10.2024 • LA Medicaid_CHIP Reg App Medical Subcontractor 07.22.24	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare provides the information regarding the grievance and appeal system to all providers and subcontractors upon the initiation of their contracts. This ensures that all parties are informed about the system at the outset of their collaboration.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
37. The MCE includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE. 42 CFR §438.228 42 CFR §438.406(b)(6) 42 CFR §438.408(f)(3) 42 CFR §457.1260(e)(5) 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	**HSAG Required Evidence:** • Policies and procedures • Member materials, such as the member handbook and/or notice templates **Evidence as Submitted by the MCE:** • 37 a,b A&GMemberPolicy, Policy Provisions, Appeal Process, Parties to the Appeal; page 4 • 37a.b UHC Member Handbook appeals section pg. 69 • 37c. UHC Member Handbook State Fair Hearings section and reversed appeals resolutions section pg. 73 • 37 c A&GMemberPolicy, Policy Provisions, State Fair Hearing Process; Parties to the State Fair Hearing, page 7	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: UnitedHealthcare includes several parties in the appeal and State Fair Hearing (SFH) processes. These parties comprise the member and their representative, the legal representative of a deceased member's estate, and UnitedHealthcare itself for the SFH. This inclusion ensures that all relevant stakeholders are involved in the appeals process.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC's member handbook did not include information that informed members that the MCE included as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE.		
Required Actions: The MCE must inform members that the MCE includes as parties to the appeal and SFH: a. The member and his or her representative. b. The legal representative of a deceased member's estate. c. For SFH, the MCE.		

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
Recordkeeping Requirements		
38. Grievance and appeal records are accurately maintained in a manner accessible to the State and available upon request to CMS, and contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance. b. The date received. c. The date of each review or, if applicable, review meeting. d. Resolution at each level of the appeal or grievance, if applicable. e. Date of resolution at each level, if applicable. f. Name of the member for whom the appeal or grievance was filed. PIHP: a. Medicaid number b. Summary of grievances and appeals; c. Current status; d. Resolution with date of resolution and resulting corrective action; 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; f. The status and resolution of all claims disputes; g. Trends and types of grievances and appeals;	**HSAG Required Evidence:** • Policies and procedures • HSAG will also use the results of the Grievances and Appeals File Reviews and the system demonstration **Evidence as Submitted by the MCE:** • 38 a, b, c, d, e, f, A&GMemberPolicy, Policy Provisions, Appeal Process, Recordkeeping, page 7 • 38 a, b, c, d, e, f, A&GMemberPolicy, Policy Provisions, Grievance Process, Recordkeeping, page 12	☒ Met ☐ Not Met ☐ NA

Standard XIII—Grievance and Appeal Systems		
Requirement	**Supporting Documentation**	**Score**
h. The number of grievances and appeals in which the PIHP did not meet timely disposition or resolution; and i. The number of State Fair Hearings and resolution during the reporting period. 42 CFR §438.228 42 CFR § 438.416(b-c) 42 CFR §457.1260(h) MCO Contract: 2.15.1.7 PAHP Contract: 2.10.1.7 PIHP Contract: 117.2		
MCE Description of Process: UnitedHealthcare accurately maintains grievance and appeal records in a manner that is accessible to LDH and available for CMS review upon request. These records include essential information such as a general description of the reason for the appeal or grievance, the date received, dates of each review or meeting, resolutions and their respective dates at each level of the appeal or grievance, and the name of the member associated with the filed appeal or grievance. This systematic documentation ensures transparency and facilitates the review process.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIII—Grievance and Appeal Systems							
Total	Met	=	31	X	1	=	31
	Not Met	=	6	X	0	=	0
	Not Applicable	=	1				
Total Applicable		=	37	**Total Score**		=	31

Total Score ÷ Total Applicable	=	**84%**

Standard XIV—Program Integrity

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
Certification		
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. 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. 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). 42 CFR §438.604(a-b) 42 CFR §438.606 42 CFR §457.1201(o) MCO Contract: None PAHP Contract: 3.3.4.3; 3.3.4.4 PIHP Contract: 16.1.4; 16.1.5; 16.1.6	**HSAG Required Evidence:** • Policies and procedures to certify the data specified in 42 CFR §438.604 • Position and job description of individual responsible for certification **Evidence as Submitted by the MCE:** • Chief Executive Officer Job Description • Chief Operating Officer Job Description, Description section, page 1 • Chief Financial Officer Job Description • Health Plan Compliance Officer Job Description **Additional Documentation:** • 0020 UHC 2024 BM18 (1)	☐ Met ☒ Not Met ☐ NA
MCE Description of Process: Each submission to LDH that requires an attestation is assigned to an Accountable Owner (AO). The AO is responsible for coordinating the efforts to obtain the information for the submission from the appropriate data sources. When the submission is complete, the AO coordinates with the individual responsible for providing the attestation, generally the Chief Operating Officer, but the Chief Executive Officer, Chief Financial Officer and Health Plan Compliance Officer may also attest depending on the submission, e.g., the Health Plan Compliance Officer is responsible for signing the Exclusion Screening monthly attestation.		

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy or process document to demonstrate compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that ensures the MCE certifies documentation or information submitted to LDH in accordance with the requirements of this element.		
Compliance Program/Program Integrity Plan		
2. The MCE develops a compliance program that includes: 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. 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. 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. 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.	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Program Integrity (PI) Annual Work Plan • Compliance Officer job description • Organizational chart • Regulatory Compliance Committee charter • Compliance training plan • Compliance training materials • Training tracking mechanisms • Communication protocol for Compliance issues (e.g., hotline) • Code of Ethics • HSAG will also use findings from the Compliance Reporting/Tracking system demonstration **Evidence as Submitted by the MCE:** • 2.a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Polices, Standards (Code) of	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO and PAHP: a. *Fraud, waste, and abuse training shall include, but not be limited to:* i. *Annual training of all employees; and* ii. *New hire training within thirty (30) Calendar Days of beginning date of employment.* b. *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. *MCO/PAHP Code of Conduct Training;* ii. *Privacy and Security - Health Insurance Portability and Accountability Act;* iii. *Fraud, Waste, and Abuse identification and reporting procedures;* iv. *The False Claims Act and employee whistleblower protections;* v. *Procedures for Timely consistent exchange of information and collaboration with LDH;* vi. *Organizational chart including the Program Integrity Officer and full-time program integrity investigator(s); and* vii. *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*	Conduct, Compliance Officer, and Compliance Oversight Committee section, page 3 – UHC Compliance Program_2024, Written Policies and Procedures section, pages 2 and 3 – UHC Anti-FWA Compliance Program_2024-2025, Policies section, page 1 – UHG Code of Conduct, Our Principles of Ethics & Integrity section, page 5, and multiple sections through the document contain an Associate Polices subsections, pages 10, 14, 18, 29, 31 – 2024 CS LA FWA and Code of Conduct Training Report • 2.b – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Polices, Standards (Code) of Conduct, Compliance Officer, and Compliance Oversight Committee section, page 3 – UHC Compliance Program_2024, Compliance Leadership and Oversight section, page 3 – Compliance and Program Integrity Org. Chart 2024, page 1 – Health Plan Compliance Officer Job Description -entire document – UHG False Claims Act Policy_2024, pages 4 & 5 • 2.c – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Polices, Standards (Code) of	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
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. c. *Effective lines of communication between the compliance officer and the organization's employees.* d. *Enforcement of standards through well-publicized disciplinary guidelines.* e. *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.* PIHP: a. *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;* b. *A description of the methodology and standard operating procedures used to identify and investigate*	Conduct, Compliance Officer, and Compliance Oversight Committee section, page 3 – COC Charter, Committee Composition/Membership section, page 1and Committee Structure and Operation section, page 2 – UHC Compliance Program_2024, Compliance Leadership and Oversight section, page 3 • 2.d – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Training and Education section, pages 3 and 4 – UHC Compliance Program_2024, Training and Education section, pages 3 and 4 – UHC Anti-FWA Compliance Program_2024-2025, Training and Education section, pages 4 and 5 • MCO: a. i-ii – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Training and Education section, page 4 – UHC Anti-FWA Compliance Program_2024-2025, Training and Education section, pages 4 and 5 – UHG Fraud, Waste and Abuse Annual Training 2024 Course Content Outline – Fraud, Waste and Abuse New Hire 2024 Course Content Outline • MCO: b. i-vii	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
fraud and abuse, and to recover overpayments or otherwise sanction providers; c. *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 appropriate, regarding suspected fraud and abuse occurrences, specifying the overpayments due to potential fraud;* d. *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* e. *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.* 42 CFR §438.608(a)(1) 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 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 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	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Training and Education section, page 4 – UHC Compliance Program_2024, Supplement to UnitedHealth Group's Compliance and Ethics Program, page 1 and Training and Education section, pages 3 – Compliance and Program Integrity Org. Chart 2024, 2-4 – UHC Anti-FWA Compliance Program_2024-2025, Training and Education section, pages 4 and 5 – UHG Code of Conduct, Our Principles of Ethics & Integrity section, page 5 – Code of Conduct New Hire 2024 Course Content Outline – UHG Code of Conduct Annual Attestation 2024 Course Content Outline – Fraud, Waste and Abuse New Hire 2024 Course Content Outline, sections 3,4,5, 6, and 8 pages 1-4 – UHG Fraud, Waste and Abuse Annual Training 2024 Course Content Outline, sections 1, 2 and 3, pages 1-8 – UHG Code of Conduct Annual Attestation 2024 Course Content Outline, section II, pages 2-3 – Code of Conduct New Hire 2024 Course Content Outline, section VII, pages 7-8 • MCO: c	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Effective Lines of Communication section, page 5 – UHC Compliance Program_2024, Effective Lines of Communication section, pages 4 and 5 – UHC Anti-FWA Compliance Program_2024-2025, Anti-FWA Program Goals and Oversight section, page 2 and Reporting Channels section, pages 3 and 4 – UHG Code of Conduct, page Reporting Misconduct section, pages 5 and 6, and Be Accountable section, page 12 • MCO: d – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 2 and Well Publicized Disciplinary section, page 5. – UHC Compliance Program_2024, Enforcing Standards- Consequences and Incentives section, pages 5 and 6 – UHC Anti-FWA Compliance Program_2024-2025, Regulatory and Law Enforcement section, page 5 – UHG Code of Conduct, Violations of the Code of Conduct and Policies section, page 5, Be Accountable section, page 12 • MCO: e	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Exclusions, Monitoring and Auditing section, page 5-6 – UHC Compliance Program_2024, Risk Assessment, Auditing and Monitoring section, pages 6 and 7 – UHC Anti-FWA Compliance Program_2024-2025, Payment Integrity and Special Investigation sections pages 2 and 3, and Prepayment Provider Reviews and Analytics section, page 4	
MCE Description of Process: The Company's overarching UHG program and the Code of Conduct govern UHC and its business segments, Community & State, Employer & Individual, and Medicare & Retirement. The UHC Compliance Program implements and administers the UHG Program into each business segment, and develops additional documentation and processes to plan, implement and document effective compliance programs for each segment's unique business and regulatory requirements. UnitedHealthcare of Louisiana, Inc. (UHCCP), the Community & State business segment of UnitedHealthcare, designates a Health Plan Compliance Officer reporting to the UHC Chief Community & State Compliance Officer and accountable to the Chief Executive Officer of UHCCP. UHCCP's program defines internal controls and policies and sits atop the United HealthCare Anti-Fraud, Waste and Abuse Program.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
3. The arrangements and procedures of the compliance program must include all of the following elements: MCO and PAHP: a. *The MCO/PAHP implements procedures for a prompt response to detected offenses and for development of corrective action initiatives.* MCO Contract: 2.20.2.2.12 PAHP Contract: 2.12.5.2.12 PIHP Contract: 13.1.2.3.8	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • 3.a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Prompt Responses to Issues section, page 14	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	– UHC Compliance Program_2024, Supplement to UnitedHealth Group's Compliance and Ethics Program section, page 1, and Responding to Detected Offenses and Developing Corrective Action Initiatives section, pages 6 and 7	
MCE Description of Process: When a credible concern or suspected misconduct is reported or identified, it is promptly reviewed to determine the appropriate course of action. Designated personnel from Compliance, Legal, and/or Investigations conduct timely and reasonable inquiries, which may include preliminary investigations, to assess the situation thoroughly. Based on the findings of these inquiries, corrective and/or disciplinary actions are implemented, as necessary. Corrective actions, coordinated by a centralized team, are further developed to address and remediate the root causes of non-compliance or violations.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
4. Additional compliance program requirements: MCO: a. *The MCO's compliance program shall incorporate the following requirements:* 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.* ii. *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*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan **Evidence as Submitted by the MCE:** • 4.a.i – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Monitoring and Auditing section, page 9 – UHC Compliance Program_2024, Overview of Fraud, Waste and Abuse Program section, page 7 – UHC Anti-FWA Compliance Program_2024-2025, FWA Prevention, Detection and Response section pages 3 and 4	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
and provider profiling algorithms, and references in provider and member materials relative to identifying and reporting fraud to the MCO and law enforcement. iii. *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.* iv. *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.* PAHP: a. *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.* b. *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*	– Algorithm Triage and Development PP – entire document – FA Prospective Prepay Investigation and Coding Review PNP – entire document • 4.a.ii – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Monitoring and Auditing section, page 9 – UHC Anti-FWA Compliance Program_2024-2025, FWA Prevention, Detection and Response section pages 3 and 4 – FWAE End to End Process, entire document – W&E Post Pay Post Pay Professional CS Policy and Procedure – entire document – FA Prospective PrePay Investigation and Coding Review PNP – entire document – UHC LA_Optum Medical Post Pay Analytics List, entire document – LA Prepay Claim Edits, entire document – Member Handbook, page 9 – Provider Manual 20241105_093245_LA_Final, page 9 • 4.a.iii – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Effective Lines of Communication section, page 5	

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relative to identifying and reporting fraud to the plan and law enforcement. c. *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.* d. *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.* e. *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.* PIHP: a. *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. *The PIHP shall develop an approval process that demonstrates the policies and procedures were*	– UHC Compliance Program_2024, Effective Lines of Communication section, pages 4 and 5 – UHC Anti-FWA Compliance Program_2024-2025, UHC Anti-FWA Compliance Program_2024-2025, FWA Prevention, Detection and Response section pages 3 and 4 – UHC-Optum - FWA Employee Reporting Site – Screenshot, entire document • 4.a.iv-2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Monitoring and Auditing section, page 11	

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reviewed and approved by the PIHP's senior management. b. *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* c. *A toll-free provider compliance hotline phone number for members and providers to report suspected fraud and/or abuse.* 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		

MCE Description of Process: UHC's Fraud, Waste, and Abuse (FWA) program is designed to ensure reimbursement accuracy and regulatory compliance through a comprehensive approach that includes prevention, detection, and response activities, such as robust reporting channels that allow employees, vendors, providers, and members to report potential FWA concerns. These channels include internal and external hotlines and electronic portals and implemented to maintain confidentiality to the extent permitted by law and policy and strictly prohibits retaliation against individuals who report concerns in good faith.

Prevention efforts are driven by prepayment provider reviews and analytics. The Anti-FWA Program uses prospective detection methods—such as pre-payment data analytics, data mining, and identification of aberrant billing patterns—to proactively identify and stop potentially fraudulent claims before payment is issued.

Detection continues post-payment through the use of advanced analytics and FWA models that identify suspicious claim patterns and provider behaviors. When such patterns are detected, the cases are escalated for further review, which may include referral to the Special Investigations Unit (SIU). Retrospective investigations are conducted by the SIU when credible suspicions of fraud are identified. These investigations focus on uncovering fraudulent activities that may have occurred against UHC health care plans and programs.

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Site visits may be conducted as part of the case's investigative strategy when the onsite may provide additional insight into the suspected fraud, waste or abuse [or] when critical information is not available [or] when critical information is apparent from sources, e.g., medical records, prescriptions, contracts, etc. Site visits may be announced or unannounced.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
5. Publicized email address: MCO and PAHP: a. *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.* b. *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.* MCO: a. *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.* PAHP: a. *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*	**HSAG Required Evidence:** • Policies and procedures • Program Integrity Compliance Plan • Evidence of publicized email address **Evidence as Submitted by the MCE:** • 5.a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Effective Lines of Communication section, page 5 – Publicized Email Address for Fraud, entire document • 5.b – UHC Compliance Program_2024, Responding to Detected Offenses and Developing Corrective Action Initiatives section, page 7 • 5 MCO: a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 1	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
its sole discretion, may require that the PAHP modify its compliance plan. MCO Contract: 2.20.2.4; 2.20.2.5 PAHP Contract: 2.12.5.3.5; 2.12.5.4 PIHP Contract: NA	– UHC Annual Compliance-FWA Plan Submission to LDH, entire document	
MCE Description of Process: UHC provides multiple confidential and secure methods for reporting compliance concerns or suspected Fraud, Waste, and Abuse (FWA). These reporting channels are designed to ensure accessibility, protect anonymity, and support timely investigation and resolution. One such method is a dedicated email address provided for reporting suspected fraud and emails received are reviewed no less than weekly. The Health Plan Compliance Officer is responsible for maintaining and updating the UnitedHealthcare of Louisiana, Inc. (UHCCP) Compliance Program. This includes submitting the program to the Louisiana Department of Health (LDH) annually, as well as at least 30 calendar days before any updates or changes are intended to take effect.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Overpayments and Treatment of Recoveries		
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. 42 CFR §438.608(a)(2) MCO Contract: 2.20.2.2.15 PAHP Contract: 2.12.5.2.15 PIHP Contract: 13.1.2.3.9	**HSAG Required Evidence:** • Policies and procedures, including timeline for prompt reporting of overpayments • Special investigations unit (SIU) workflows • Identification mechanisms • Reporting mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • 6	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
	– 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 – UHC Anti-FWA Compliance Program_2024-2025, Regulatory Reporting section, page 4 – Louisiana Medicaid Reg App, Medicaid Laws and Regulations section, iii.h, page 5 – UHC 145 2024 Q4, entire document – UHC 145 LDH Submission Confirmation, entire document – Anti-Fraud, Waste and Abuse Program – Retrospective Investigations, page 2 – MCE Fraud Referral Template, page 1	
MCE Description of Process: UnitedHealthcare of Louisiana, Inc. (UHCCP) is committed to ensuring timely, accurate, and complete reporting of its anti-Fraud, Waste, and Abuse (FWA) activities and performance. Overpayments identified through these efforts are reported to the Louisiana Department of Health (LDH) immediately upon discovery, using the state-provided referral form. In addition, a quarterly report is submitted to LDH that summarizes all overpayments identified and recovered through retrospective investigations, as well as waste and error detection efforts. Relevant data is collected from the appropriate operational teams and consolidated by the reporting teams into the state-provided reporting template.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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.	**HSAG Required Evidence:** • Policies and procedures • Overpayment tracking mechanisms • Provider materials, such as the provider manual and provider contract • Staff training materials	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
a. The MCE complies with the process, timeframes, and documentation required by LDH for reporting the recovery of all overpayments. 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. c. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. MCO: a. *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.* PAHP: a. *The PAHP shall report overpayments made by LDH to the Contractor within sixty (60) calendar days from the date the overpayment was identified.* b. *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.* PIHP: a. *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.*	• Most recent report of recoveries of overpayments to State **Evidence as Submitted by the MCE:** • 7.a – 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 – UHC Anti-FWA Compliance Program_2024-2025, Regulatory Reporting section, page 4 – UHC 145 2024 Q4, entire document – UHC 145 LDH Submission Confirmation, entire document • 7.b. – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Monitoring and Auditing section, page 12 • 7.c.- 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Monitoring and Auditing section, page 12 • MCO: a. – 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 – UHC Anti-FWA Compliance Program_2024-2025, Regulatory Reporting section, page 4	

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Requirement	**Supporting Documentation**	**Score**
Reporting must specify which overpayments are attributed to potential fraud. b. *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.* 42 CFR §438.608(d)(1) 42 CFR §438.608(d)(3) 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		
MCE Description of Process: A quarterly report is submitted to LDH that summarizes all overpayments identified, recovered through retrospective investigations, waste and error detection efforts as well as unsolicited provider refunds. Relevant data is collected from the appropriate operational teams and consolidated by the reporting teams into the state-provided reporting template. The state provided template is cumulative for each quarter and results in an annual report. When the Louisiana Department of Health (LDH) or its designee notifies UnitedHealthcare of Louisiana, Inc. (UHCCP) that it is prohibited from recouping or withholding payments from a provider for improperly paid funds have already been recovered by the State of Louisiana, either directly through the Louisiana Medicaid Program or as part of a resolution involving a state or federal investigation, audit, or legal proceeding, including but not limited to False Claims Act cases, UHCCP will suspend any such actions. If UHCCP inadvertently recovers funds in violation of these restrictions, LDH reserves the right to recover those funds directly from UHCCP through a deduction from its monthly capitation payment from LDH.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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	**HSAG Required Evidence:** • Policies and procedures • Overpayment and monitoring mechanisms	☒ Met ☐ Not Met

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Requirement	**Supporting Documentation**	**Score**
calendar days after the date on which the overpayment was identified, and to notify the MCE in writing of the reason for the overpayment. 42 CFR §438.608(d)(2) MCO Contract: 2.20.2.2.14 PAHP Contract: 2.12.5.2.14 PIHP Contract: 3.1.12	• Provider materials, such as the provider manual and provider contract • Staff training materials **Evidence as Submitted by the MCE:** • 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 • Louisiana Medicaid Reg App, Medicaid Laws and Regulations section, iii.h, page 5 • Provider Manual 20241105_093245_LA_Final, pages 7 and 8 • Claims-Overpayment – Refund -Form- entire document	☐ NA
MCE Description of Process: Under the terms outlined in the Louisiana Regulatory Appendix, network providers are contractually required to report any identified overpayments to UnitedHealthcare of Louisiana, Inc. (UHCCP). Providers must return the overpayment within sixty (60) calendar days of identification and submit a written explanation detailing the reason for the overpayment. Refunds are processed by UHCCP's recovery team and included in quarterly reports submitted to the Louisiana Department of Health (LDH).		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Notification of Member and Provider Changes		
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	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • 9 a and b	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
circumstances that may affect the member's eligibility including all of the following: a. Changes in the member's residence; b. The death of a member. 42 CFR §438.608(a)(3) MCO Contract: 2.20.2.2.8 PAHP Contract: 2.12.5.2.10 PIHP Contract: 14.8.1.4	– 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 – Demographic Changes Member Services SOP, Permanent Address section, pages 3 and 3 – Deceased Member Notification SOP, Advocate Action section, page 2 – LDH Confirmation File-LAMEDS Success 20241202-160845	
MCE Description of Process: When UHC receives information about changes to a member's circumstances, these changes are noted in the membership systems and communicated systematically each afternoon daily to LDH and UHC receives a confirmation file back from LDH. This file exchange contains data elements such as name, address, phone numbers, email addresses, preferred language, marital status, Social Security Number, Date of Birth, date of death, and incarceration status.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
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. PAHP: a. *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*	**HSAG Required Evidence:** • Policies and procedures • Staff training materials **Evidence as Submitted by the MCE:** • 10 – 2024 UHCCP FWA Plan LA-CE-Policy 001 (a), Reporting section, page 18 – Practitioner Sanctions Monitoring Policy (11-11-24), Policy Statement and Purpose section, page 1 and section Procedural Guideline for Policy Compliance section pages 2-5	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
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. *Information about how the provider network change will affect the delivery of covered services; and* ii. *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.* PIHP: a. *The PIHP shall notify LDH within one (1) business day of the PIHP becoming aware of any unexpected changes (e.g., a provider becoming unable to care for members due to provider illness, provider death, relocation from the service area and fails to notify the Contractor, or when a provider fails credentialing or is displaced as a result of a natural or man-made disaster) that would impair its provider network [42 CFR §438.207(c)]. The notification shall include:* i. *Information about how the provider network change will affect the delivery of covered services, and* ii. *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.* 42 CFR §438.608(a)(4) MCO Contract: 2.20.2.2.9 PAHP Contract: 2.6.7.6; 2.12.5.2.11 PIHP Contract: 6.6.5	– Debarment and Exclusions Monitory (5-14-204) policy, Policy Statement and Purpose section, page 1 and Procedural Guidelines for Policy Compliance, pages 2-4 – Provider Sanctions Monitoring Policy and Procedure, Overview section, page 1 and 4.0 Notification and Communication section, page 6 – Clinical Practitioner Sanctions, Monitoring policy, Policy Statement and Purpose section, page 1, Policy Provisions section, page 2 – Provider Social Security Death Master File Monitoring Policy, Background section page 1 and Data Governance section, page 3. – LDH Notification of Termination for Cause-Example, entire document	
MCE Description of Process: UnitedHealthcare of Louisiana, Inc. (UHCCP) monitors federal, and state exclusion lists as well as state licensing boards. For individuals located in Louisiana, any positive sanction or exclusion matches or termination for cause are reported to		

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the Health Plan Compliance Officer (HPCO). When applicable, the HPCO communicates these findings to the Louisiana Department of Health (LDH) Program Integrity Contact to ensure compliance with state-specific regulatory requirements and to facilitate proper coordination. Terminations that are not related to fraud or sanctions, are reported to LDH via standard reporting requirements.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Verification of Services Provided		
11. The MCE (or subcontractor, to the extent that the subcontractor is delegated responsibility by the MCE for coverage of services and payment of claims under the Contract between LDH and the MCE) implements and maintains arrangements or procedures for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. MCO: a. *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. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished;* iv. *The amount of the payment made for the service; and*	**HSAG Required Evidence:** • Policies and procedures • Methodology for verifying services • Most recent results from the Medicaid verification of services activity • Staff training materials **Evidence as Submitted by the MCE:** • 11a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Verification of Services section, pages 16 and 17 – Sample Explanation of Benefits – Shutterfly Work Flow, entire document • 11b – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Verification of Services section, page 17 – Report Logic for Claims Sample, entire document	☒ Met ☐ Not Met ☐ NA

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Requirement	**Supporting Documentation**	**Score**
v. *The method for notifying the Contractor of services not rendered.* b. *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.* c. *The notices may be provided by mail, telephonically, or in person (e.g., case management on-site visits).* d. *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.* e. *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*. f. *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*	• 11c – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Verification of Services section, page 16 – Verification of Service Calls SOP, Policy, Objective, Considerations and Process section, page 1 – LA Verification of Services Call Script, Verification of Services section, page 2 – September 2024 Verification Call Results, columns AB, AC and AD • 11d – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Verification of Services section, page 17 – Verification of Service Calls SOP, Procedure for Verification of Service Calls section, page 2 – LA Verification of Services Call Script, Verification of Services section, page 2 – September 2024 Verification Call Results, columns AB, AC and AD – Customer Service FWA Referral, FWA Documentation Guidelines section, page 1 and Scenarios and Examples of FWA section, pages 10-12 • 11e	

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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. PAHP: a. *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 manger that complies with 42 CFR §455.20 and §433.116(e). In easily understood language, the required notice must specify:* i. *Description of the service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *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.* c. *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*	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Verification of Services section, page 17 – Verification of Service Calls SOP, Procedure for Verification of Service Calls section, page 2 – LA Verification of Services Call Script, Verification of Services section, page 2 – September 2024 Verification Call Results, columns AB, AC and AD – Customer Service FWA Referral, FWA Documentation Guidelines section, page 1 and Scenarios and Examples of FWA section, pages 10-12 • 11f – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Reporting section, page 19 – LA 147 Job Aid 8.2023, entire document – UHC 147 2024 Q4 – UHC 147 LDH Submission Confirmation, entire document	

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d. *Track any complaints received from enrollees and resolve the complaints according to its established policies and procedures.* e. *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.* f. *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.* PIHP: a. *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. *The service furnished;* ii. *The name of the provider furnishing the service;* iii. *The date on which the service was furnished; and* iv. *The amount of the payment made for the service.* b. *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*		

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Contractor shall submit the methodology to LDH for prior approval. c. *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.* d. *The Contractor shall over sample particular provider groups upon request by LDH.* e. *The Contractor shall track any feedback received from members. The Contractor shall use the feedback received to modify or enhance the verification of receipt of paid services sampling methodology.* f. *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.* g. *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.* 42 CFR §438.608(a)(5) MCO Contract: 2.20.2.2.10; 2.18.11.1 PAHP Contract: 2.14.6.		

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Requirement	**Supporting Documentation**	**Score**
PIHP Contract: 15.4		
MCE Description of Process: Each month, in an automated process, in accordance with contractual requirements for timing, sampling percentage, and stratification, a verification file is generated and automatically sent to an external vendor, Shutterfly. This file is used to produce and mail Explanation of Benefits (EOBs) to members. At the same time, the HARC team receives a copy of this file to support service verification efforts. Noting, telephonic surveys ended in September 2024. Using the data provided, the HARC team contacts members to confirm whether the listed services were received, continuing outreach until 100 completed calls are achieved. All call outcomes are documented in monthly reports, which are stored in a designated location for tracking and compliance purposes. The EOBs that are mailed, instruct the member to contact customer service to report services that were not received. If a member reports that they did not receive a service listed on their EOB, the HARC team submits a tip through EthicsPoint and notifies the Health Plan Compliance Officer (HPCO) via email. Upon receiving this information, the HPCO completes a Louisiana Department of Health (LDH) Notification Form within the timeframes specified in the contract. In 2024, there were 4 respondents; however, the HPCO did not receive an email notification so there was no report to LDH. If Customer Service receives a call regarding unverified services, a FWA referral (Tip) is submitted. A quarterly report is submitted to LDH summarizing the verification activities. This report includes the total number of EOB notices sent to enrollees, the number of services selected for validation, the number of member responses received, the number of services validated, an analysis of any interventions taken to resolve discrepancies, and the number of cases referred to LDH for further review.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Whistleblower Protection		
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	**HSAG Required Evidence:** • Policies and procedures • Program integrity/compliance plan • Staff, Provider, and Subcontractor training/informational materials **Evidence as Submitted by the MCE:** • 12a	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
section 1902(a)(68) of the Social Security Act, including information about rights of employees to be protected as whistleblowers. MCO: 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. 42 CFR §438.608(a)(6) 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	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Training and Education section, page 4 – Fraud Waste and Abuse New Hire 20245 Course Content Outlie, section 7f., page 4 – UHG Fraud, Waste and Abuse Annual Training 2024 Course Content Outline, section 3, e.iii	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Fraud, Waste, and Abuse		
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: a. That are designed to detect and prevent fraud, waste, and abuse. b. For the prompt referral of any potential fraud, waste, or abuse that the MCE identifies to LDH's program	**HSAG Required Evidence:** • Policies and procedures • Fraud, waste, and abuse plan • SIU workflow • Reporting mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • 13a	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit (MFCU). PAHP: a. *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).* PIHP: a. *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.* 42 CFR §438.608(a) 42 CFR §438.608(a)(7) MCO Contract: 6.18.2 PAHP Contract: 2.12.6.1 PIHP Contract: 13.1.2.4	– 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 1 – UHC Compliance Program_2024, Overview of Fraud, Waste and Abuse section, page 7 – UHC Anti-FWA Compliance Program_2024-2025, FWA Prevention, Detection and Response section, pages 3 and 4 – FWAE End to End Process, entire document – Algorithm Triage and Development PP, entire document – FA Prospective PrePay Investigation and Coding Review PNP, entire document – Anti-Fraud, Waste and Abuse Program – Retrospective Investigations, entire document • 13b – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 1, Monitoring and Audit section, 11 and Reporting section, page 17 – UHC Compliance Program_2024, Overview of Fraud, Waste and Abuse section, page 7 – UHC Anti-FWA Compliance Program_2024-2025, Regulatory Reporting section, page 4 – Anti-Fraud, Waste and Abuse Program – Retrospective Investigations, page 2 – LA_FraudReferralRequirement, entire document	

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
	– Sample Fraud Referral Submissions to LDH, entire document	
MCE Description of Process:		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Suspension of Payments		
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. 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.2.2.11 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.22	**HSAG Required Evidence:** • Policies and procedures • Payment suspension workflow • Staff training materials **Evidence as Submitted by the MCE:** • 14-2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Exclusions and Prohibitions section, page 8 and Prompt Responses to Issues, section, page 13 • Provider Payment Suspension Placement SOP, Purpose and Procedures sections, pages 1 and 2	☒ Met ☐ Not Met ☐ NA
MCE Description of Process: The Health Plan Compliance Officer (HPCO) and Program Integrity Manager (PIM) typically receive a notification from the Louisiana Department of Health (LDH) or its designee requesting the suspension of payments to specific providers. The PIM sends the relevant information to the Business Control Unit (BCU) team in accordance with the Provider Payment Suspension Notice (PPSN) process or its equivalent local procedure.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
	HSAG Required Evidence:	☒ Met

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
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). 42 CFR §438.608(a)(8) 42 CFR §455.23 MCO Contract: 2.20.1.11.7 PAHP Contract: 2.12.2.2 PIHP Contract: 13.5.19	• Policies and procedures • Payment suspension workflow, including applicable timeframes • Notice of payment suspension letter template • Staff training materials • HSAG will also use findings from the provider payment suspensions tracking system demonstration **Evidence as Submitted by the MCE:** • 15-2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Exclusions and Prohibitions section, page 8 • Sample Template Notice, entire document	☐ Not Met ☐ NA
MCE Description of Process: Upon receiving this request, the HPCO or PIM prepare suspension notices using a standardized template. This template must be used exactly as written to ensure compliance with the requirements outlined in 42 CFR 455.23. All notices must be sent to the identified providers via certified mail to ensure proper documentation and delivery.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
Provider Screening and Enrollment Requirements		
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. 42 CFR §438.608(b) 42 CFR §457.990 42 CFR Part 455, Subparts B and E	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment verification workflow • Two examples of documented Medicaid enrollment verifications • Staff training materials	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCO Contract: 2.9.7.1 PAHP Contract: 2.6.3.1 PIHP Contract: 6.53	**Evidence as Submitted by the MCE:** • 16 – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 2 – UHC Anti-FWA Compliance Program_2024-2025, Sanction, Exclusion and Preclusion section, page 4 – PES Provider Enrollment Flow, entire document	
MCE Description of Process: LDH implemented the Provider Enrollment requirements using a phased-in approach. Once providers receive their invitations from LDH, they are required to enroll in Medicaid. LDH communicates a daily file containing up-to-date information on each provider and their enrollment status. UHC maintains an automated process to ingest the LDH file and if the file indicates the provider is not eligible, systems are updated to prohibit claims from being paid.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		
17. The MCE may execute network provider agreements pending the outcome of screening, enrollment, and revalidation processes of up to 120 days. a. The MCE terminates a network provider immediately upon notification from LDH that the network provider cannot be enrolled, or the expiration of the 120 day period without enrollment of the provider, and notify affected members. 42 CFR §438.602(b)(2) MCO Contract: 2.9.7.2 PAHP Contract: 2.6.9.1 PIHP Contract: 6.5.5	**HSAG Required Evidence:** • Policies and procedures • Medicaid enrollment timeliness tracking mechanisms • Staff training materials **Evidence as Submitted by the MCE:** • PES Provider Enrollment Flow, entire document **Additional Documentation:** • Narrative Execute or Terminate providers within 120 days of failing Provider Enrollment	☐ Met ☒ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
MCE Description of Process: LDH's current multi-phase provider enrollment implementation has resulted in provider status inconsistencies. A provider may fail enrollment today, then remediate their situation and complete enrollment a few days or a few weeks later. Claims begin denying the day that provider fails the enrollment process, but unless we can verify that the provider retired, passed, relocated out of state, or closed their business, we opt for monitoring for future activity via the daily Provider Enrollment files. This reduces member disruption for both PCP linkages, and specialist access. If LDH decides in the future that once a provider fails, they can never come back, or cannot come back for xx months, we can immediately implement a process to terminate providers immediately upon failure.		
HSAG Findings: HSAG has determined that the MCE has not met the requirements for this element. UHC did not submit a policy or describe a process to demonstrate compliance with the requirements of this element.		
Required Actions: The MCE must develop a policy that complies with the requirements of this element.		
Disclosures and Prohibited Affiliations		
18. The MCE, and any subcontractors: a. Provides written disclosure of any prohibited affiliation under 42 CFR §438.610. b. Provides written disclosures of information on ownership and control required under 42 CFR §455.104. c. Reports to LDH within 60 calendar days when it has identified the capitation payments or other payments in excess of amounts specified in the Contract. MCO: a. *Notify LDH in writing upon receipt of any voluntary provider disclosures resulting in receipt of overpayments in excess of twenty-five thousand dollars ($25,000), even if there is no suspicion of fraudulent activity.* 42 CFR §455.104 42 CFR §438.608(c) 42 CFR §438.610	**HSAG Required Evidence:** • Policies and procedures that apply to provider/contracted entities and the MCE • Provider materials, such as contract template or provider manual (requiring disclosures within 35 days after any change in ownership) • Disclosure of ownership and control notice template (required for completion by contracted entities) • Confirmation MCE disclosures were provided to LDH upon contract execution • Staff training materials **Evidence as Submitted by the MCE:** • 18a – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Exclusion and Prohibitions, section, pages 6,7, and 8	☒ Met ☐ Not Met ☐ NA

Standard XIV—Program Integrity		
Requirement	**Supporting Documentation**	**Score**
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	• 18b – 2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), Policy and Overview section, page 2 – LA Disclosure Program Policy 2024, Purpose section, pages 1 and 2 and Policy section, page 2 – Combined Individual and Entity Disclosure Form, entire document • 18c – 0020 UHC 2024 BM18 (1) – 0020 UHC 2024 LDH Submission Confirmation, entire document • 18 MCO: a-2024 UHCCP FWA Compliance Plan LA-CE-Policy 001 (a), page 19	
MCE Description of Process: The Health Plan Compliance Officer (HPCO) provides written notice of any prohibited affiliation to the LDH Program Integrity contact within three business days of receiving the notification. The UHC Provider Data Operations team collects ownership disclosure information for providers that are not enrolled with LA Medicaid; however, are otherwise allowed to participate in the LA Medicaid Program. Individuals and entities included on the acquired disclosure forms are monitored for sanctions and exclusions and are reported to LDH, if applicable in the same manner as other provider sanctions and exclusion monitoring. UHC provides LDH with the 0020 Report on a bi-monthly basis, which includes the results of our review of suspected inaccuracies with our capitation payments. Our review is based on a comparison of 820 capitation payments, if the payment contains member level detail, which is not always included, and 834 eligibility records received from LDH. Discrepancies could include improper rate cell/capitation amount, payment for members without an eligibility record, or missing payment for members with an eligibility record.		
HSAG Findings: HSAG has determined that the MCE met the requirements for this element.		
Required Actions: No action required.		

Results for Standard XIV—Program Integrity							
Total	Met	=	16	X	1	=	16
	Not Met	=	2	X	0	=	0
	Not Applicable	=	0				
Total Applicable		=	18	**Total Score**		=	16

Total Score ÷ Total Applicable	=	**89%**

Appendix C. 2025 Corrective Action Plan Template

Standard <#>			
Requirement	**Evidence as Submitted by the MCE**		**Score**
1. <Insert federal CFR citation> Contract: <Insert Citation(s)>	**MCE Document Submission:** •		☐ Met ☐ Not Met
HSAG Findings:			
Required Actions:			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
CAP Approval Status:			
Submission:			